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A REVIEW INTO THE OPERATION OF **CARE AND SUPERVISION UNITS IN THE NORTHERN IRELAND PRISON SERVICE**

FEBRUARY 2022

The **Regulation** and **Quality Improvement** Authority

Criminal Justice Inspection Northern Ireland
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national preventive mechanism

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February 2022

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HM Inspectorate of Prisons

eti

The Regulation and Quality Improvement Authority

CONTENTS

LIST OF ABBREVIATIONS

AD:EPT	Alcohol and Drugs: Empowering People Through Therapy (treatment service for adults)
Belfast Met	Belfast Metropolitan College
CC	Cellular confinement
CJI	Criminal Justice Inspection Northern Ireland
CSU(s)	Care and Supervision Unit(s)
DoJ	Department of Justice
EMIS	Egton Medical Information System
ETI	Education and Training Inspectorate
GOOD	Good Order or Discipline
GP	General Practitioner
HMIP	Her Majesty's Inspectorate of Prisons in England and Wales
HPSS	Health and Personal Social Services
HQ	Headquarters
ILP	Individual Learning Plan
IMB	Independent Monitoring Board
IT	Information Technology
MHT	Mental Health Team
NIPS	Northern Ireland Prison Service
NWRC	North West Regional College
OMB	Operational Management Board
OPCAT	Optional Protocol to the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
PDP	Personal Development Plan
PDU	Prisoner Development Unit
PE	Physical Education
PREPs	Progressive Regimes and Earned Privileges scheme
PRISM	Prison Record Information System Management (computer system used by the NIPS)
PSMB	Prison Service Management Board
PSST	Prisoner Safety and Support Team
SEHSCT	South Eastern Health and Social Care Trust
SOP	Standard Operating Procedure
SPAR & SPAR Evolution (Evo)	Supporting Prisoners at Risk and Supporting People at Risk Evolution (Evo)
RQIA	Regulation and Quality Improvement Authority

REPORT TERMINOLOGY

Prisoners
The Northern Ireland Prison Service uses the term 'student' to describe young men held in custody at Hydebank Wood Secure College and 'people in our care' to describe all adults. This report uses the term 'prisoner' for everyone held in custody and the term 'patient' when reporting on health care.

Prison names
Full prison names have been abbreviated as follows:

- Maghaberry Prison to 'Maghaberry';
- Magilligan Prison to 'Magilligan';
- Ash House Women's Prison to 'Ash House'; and
- Hydebank Wood Secure College to 'Hydebank Wood'.

Hydebank
Hydebank Wood Secure College and Ash House Women's Prison share a single site in Belfast. When commenting on the site it is referred to as Hydebank.

Cells
Hydebank Wood Secure College refers to prisoner cells as rooms. This report uses the term cell to describe all prisoner accommodation.

Governor's Disciplinary awards
This term is shortened to 'award' by The Prison and Young Offenders Centres Rules (Northern Ireland) 1995 and is used throughout this report. It describes punishment outcomes imposed by a Prison Governor at disciplinary adjudication proceedings when there is a finding of guilt.

SPAR (Supporting Prisoners at Risk)
Any reference to SPAR should be read in the context of the follow explanation. Operating procedures for the prevention of suicide and self-harm were called SPAR prior to June 2019. This was a collaborative approach between the Northern Ireland Prison Service, South Eastern Health and Social Care Trust and other key stakeholders. It was based on the need for a 'Whole Prison' approach, combined with a targeted 'person centred' approach for those at high risk from suicide and self-harm behaviours. A revised version of SPAR called Supporting People at Risk (SPAR) Evolution (or SPAR Evo) rolled out to the service between June 2019 and August 2020.

CHIEF INSPECTOR'S FOREWORD

Prisoners and their families, the Minister of Justice and her officials, as well as the Northern Ireland Assembly and wider community, should be appropriately assured and confident that prisoners held in Care and Supervision Units in Northern Ireland prisons are experiencing a regime that at least meets required minimum standards for the treatment of prisoners.

The importance of this and providing adequate evidence that it is happening, should be the business of every person interacting with or providing services to prisoners in Care and Supervision Units.

The Minister of Justice requested this Review and I agreed to carry it out in the knowledge that it would be different from an unannounced prison inspection, that it required a partnership approach with the Regulation and Quality Improvement Authority and Education and Training Inspectorate and that it required the Inspection Team to carry out fieldwork in each prison during the COVID-19 pandemic (the pandemic).

Care and Supervision Units within our prisons are places of segregation, of surveillance and of punishment for breaking Prison Rules. Some of the prisoners held in Care and Supervision Units are among the most vulnerable and complex in the care of the Northern Ireland Prison Service and South Eastern Health and Social Care Trust. In recent years the Northern Ireland Prison Service ethos of referring to all prisoners as '*people in our care*' has been emphasised internally, across Government and to the wider community. Providing the care required for some prisoners can be especially challenging for those with the most profound needs who can often be found in Care and Supervision Units.

Regardless of why prisoners are in a Care and Supervision Unit, there are United Nations minimum standards and accepted Expectations for their treatment including access to health care and purposeful activity. This Review found the treatment of some prisoners and patients did not meet the expected Standard Minimum Rules and what some experienced was solitary confinement, sometimes despite the best efforts of Prison Officers and health care staff. I appreciate this is a hard message for many involved in the care of prisoners to hear, particularly the Northern Ireland Prison Service given their dedicated efforts in keeping prisoners safe from the COVID-19 virus during the pandemic.

Meaningful human contact goes beyond asking someone at a cell door if they have any requests, do they want a shower or placing a food tray through their door. It is not transferring them from one cell to another each day while their cell is deep cleaned.

Establishing and maintaining meaningful human contact with prisoners who do not, or cannot, engage can be extremely challenging. It requires skilled and committed staff with access to support and specialist advice when needed. This Review found evidence that opportunities for engaging in or maintaining learning and skills, physical or other purposeful activity were very limited and using these activities as opportunities to have conversations were missed by some prisoners who needed them most.

During this Review the Northern Ireland Prison Service was focussed on managing the impact of the pandemic on its staff and service delivery including the care of prisoners. A time when some prisoners were spending 14 days in isolation before transferring to the Care and Supervision Unit for a further period of segregation. A time when prisoners in the Care and Supervision Units were reliant on Prison Officers and health care staff to provide the meaningful human contact and time out of cell required to prevent them being held in solitary confinement.

The comprehensive off-site fieldwork undertaken also included reviews of information technology and paper records, journals, closed circuit television and body worn camera footage, other data and records. The Inspection Team spent many hours attempting to locate and piece together disjointed sources of information to provide evidence of the regime and treatment experienced by prisoners and standards being met. I believe that without appropriate evidence it is not possible to provide satisfactory assurance.

The Northern Ireland Prison Service need to better govern and manage the use of Care and Supervision Units across the prison estate through a cohesive and clear strategy that translates into quality services supported by quality records focussed on delivering against required standards and Expectations and improving prisoner outcomes. But it isn't just about better systems and records it is about believing that they are important and knowing how to use information to make a difference to each prisoner's care.

During this Review, I met impressive and committed Prison Officers and health care staff in Care and Supervision Units who face complex challenges every day and knew that words matter and make a difference. However, all Care and Supervision Unit staff need the skills, energy and motivation to identify individual needs and take care of those most vulnerable, challenging and disengaged prisoners in the best way they can. Recruiting and training the right people for these important roles needs to be reviewed.

This Review report, like others in the past and more recently, comments on the lack of acute in-patient facilities in our prisons for prisoners with severe mental health and/or behavioural issues, despite a known need for them for a long time.

The Northern Ireland Prison Service is embarking on a new period of corporate planning and consultation on its vision for future service delivery in the context of anticipated funding pressures.

There is a clear commitment to continuous improvement and I expect the Director General and his leadership team will take the opportunity to consider all the recommendations in this report and, working with the Department of Justice and its partners, specifically reflect them in its future plans and priorities to improve prisoner outcomes. I will also be thinking about our learning from this Review and how we follow-up on the recommendations in future prison inspections.

This Review introduced additional challenges and complexities for the entire Inspection Team and the Northern Ireland Prison Service that I do not under estimate and I fully appreciate. I am very grateful to our partner Inspectors from the Regulation and Quality Improvement Authority and Education and Training Inspectorate, especially for their willingness to undertake this Review and the additional planning, risk management and health and safety logistics that entailed.

I am also grateful to two Inspectors from Her Majesty's Inspectorate of Prisons in England and Wales for their consideration of and helpful feedback on the draft Review report. My particular thanks to the Lead Inspector Stevie Wilson, and Inspectors Maureen Erne and Muireann Bohill, for their dedicated commitment at all stages of this Review and progressing it to conclusion.

Finally, I express my thanks to the staff from the Northern Ireland Prison Service, South Eastern Health and Social Care Trust, Belfast Metropolitan College and North West Regional College who helpfully contributed to this Review as well as stakeholders and importantly, the prisoners who shared their views and experiences of the Care and Supervision Units with us.

Jacqui Durkin
Chief Inspector of Criminal Justice in Northern Ireland

February 2022

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EXECUTIVE SUMMARY

This Review was carried out after the Chief Inspector of Criminal Justice in Northern Ireland received a request from the Minister of Justice following significant concerns being raised with her about the operation of Care and Supervision Units in Northern Ireland prisons. Inspectors from Criminal Justice Inspection Northern Ireland and the Regulation and Quality Improvement Authority worked in partnership to fulfil our responsibilities to deliver independent and objective assessments of outcomes for prisoners in accordance with the United Kingdom's responsibilities as signatory to the Optional Protocol to the Convention against Torture. As part of this partnership, the Education and Training Inspectorate provided independent inspection services on the quality of education and purposeful activity.

Each Care and Supervision Unit was visited at each prison during the Covid-19 pandemic followed by extensive off-site fieldwork in the months that followed. During this time the Northern Ireland Prison Service's corporate priority was keeping Covid-19 out of the prison population and effectively managing prison regimes within available resources.

Prisoners are segregated in Care and Supervision Units for a number of reasons, these include for their own safety or the safety of others, for breaking Prison Rules or for suspicion of holding drugs or other items on their person. Some prisoners have severe mental disorders and needs that make them particularly challenging for staff to care for and it is questionable if prison is the most appropriate place for them to be.

The reasons for segregation in Care and Supervision Units were wide ranging and extended far beyond that of punishment alone. Regardless of this, most prisoners still saw it as a place they went for punishment and frequently described it to Inspectors as *"the block"*. Some were there because it was considered inappropriate to accommodate them elsewhere within the prison and some remained there purely because of their severe mental illness and/or their challenging behaviours.

Some prisoners were punished with cellular confinement at disciplinary hearings and additional punishments imposed at the same time ultimately resulted in further loss of privileges. When serving periods of cellular confinement in the Care and Supervision Units some also had further privileges removed.

Overall, there was little distinction in the conditions and treatment of those in cellular confinement and those who were not.

The Northern Ireland Prison Service did not have a strategy for the operation and future development of Care and Supervision Units despite a documented and well publicised corporate ethos of prisoners being treated as *'people in our care'*. This lack of corporate oversight had enabled varying practices and was hampering opportunities to improve outcomes for segregated prisoners.

Data was not monitored or used effectively to strategically identify organisational trends nor to implement actions to mitigate excessive use. Management information for each Care and Supervision Unit was also inadequate, making it impossible to appropriately monitor service delivery and prisoner outcomes achieved.

The shared Care and Supervision Unit at Hydebank for young men and women did not provide 'entirely separate' facilities. This was out of step with the Mandela Rules and with Her Majesty's Inspectorate of Prison's *Expectations* for women. The Northern Ireland Prison Service needs to address this urgently and develop a vision, strategy and action plan that addresses the separate needs of women held in a Care and Supervision Unit.

The Department of Justice is required by the Prison Rules to review and provide agreement, when it is appropriate, for applications by the prisons to extend a prisoner's segregation in a Care and Supervision Unit beyond 72 hours. In practice, the Northern Ireland Prison Service approved the applications.

Almost 3,000 extensions had been agreed in a six-year period but without monitoring of the oversight process or application trends. The Northern Ireland Prison Service was not exercising effective governance over extensions and did not recognise the importance of doing so.

Some prisoners spent long periods locked in their cells. Care and Supervision Unit regimes were predictable, restrictive and exclusively focused on fulfilling institutional routines. There was an uncomfortable reliance on a culture dependent on each prisoner making a 'Request' for basic needs. Association with other prisoners was not routinely assessed or provided. Opportunities to participate in purposeful activity, including learning and skills, and physical activity were not proactively encouraged and the library services in Magilligan Prison and Maghaberry Prison were limited.

Evidence of purposeful activity and of time out of cell was poor. Meaningful human contact and interactions with prisoners was not sufficiently recorded and evidenced. Too much reliance was placed on outdated paper-based records that had limited evidence of supervisory checks and no evidence of audit. The records examined by Inspectors failed to dispel wider evidential concerns about the length of time prisoners spent in their cells and the lack of meaningful human contact with them. In the absence of those assurances, Inspectors concluded from their fieldwork that a number of prisoners in Care and Supervision Units had experienced conditions amounting to solitary confinement (as defined by the *Mandela Rules*).

Prisoners with severe mental health illness and/or challenging behaviours, were still being segregated in Care and Supervision Units. The facilities were inadequate and there were insufficient professional health care staff to care for and treat them. The Northern Ireland Prison Service in partnership with the South Eastern Health and Social Care Trust and their governing Departments need to take urgent action to address this. Initial health assessments were not taking place during the first two hours with some taking almost double that and only at Magilligan Prison was there evidence that a health care prisoner algorithm was in use.

The prison staff and the health care teams were challenged daily to meet individual needs. Inspectors found some good examples of individually tailored care plans and serious case reviews. At Maghaberry Prison in 2018, exit planning for the longer stayers was good, but generally, this work had taken a backwards step across all prisons. Overall, the plans identifying exit and reintegration pathways were inconsistent and in some instances did not exist at all. Plans were not being initiated immediately at the point of entry and when considered, this occurred too late into the segregation period or during the final days of segregation.

Initiatives at Hydebank Wood intending to improve its Care and Supervision Unit for young men and the sensory garden attached to the Care and Supervision Unit at Magilligan Prison are encouraging but were under-utilised. To improve prisoner outcomes, all Care and Supervision Units should provide quality facilities that recognise the needs of the prisoners sent to and segregated in them.

While the COVID-19 pandemic created some restrictions on engagement, it was the environment and perceptions of the Care and Supervision Units and of staff that were the long-term hurdles to improving meaningful engagement with prisoners.

Inspectors met many prison and health care staff who were committed to their role and who demonstrated compassion for the prisoners and patients in their care. But they are hindered by the limitations of the present facilities and a need for better training to improve outcomes for prisoners. There was a clear need for appropriate staff selection procedures, training and support and recommendations have been made in this report to address these issues.

RECOMMENDATIONS

STRATEGIC RECOMMENDATIONS

STRATEGIC RECOMMENDATION **1**

The Northern Ireland Prison Service should develop a vision, strategy and action plan for the effective operation of Care and Supervision Units within nine months of publication of this report and incorporate the following:

- a framework for the operation of Care and Supervision Units which reflects minimum standards for the treatment of prisoners held in segregation including guidance on the interpretation of 'meaningful human contact';
- a plan for the development of Care and Supervision Unit accommodation and facilities to support effective delivery and improved outcomes for prisoners modelled on the design principles underpinning the Care and Supervision Unit at Hydebank and of Davis House;
- in collaboration with the Department of Justice, a review of Rule 32 policy, guidance and audit of practice, care and reintegration planning;
- effective arrangements for governance, audit and oversight of those held in Care and Supervision Units including the development of relevant data capture methods and management information to meet Northern Ireland Prison Service and Department of Justice assurance needs; and
- processes to select, train and support staff and managers working in Care and Supervision Units including clinical supervision.

(paragraph 2.8)

STRATEGIC RECOMMENDATION **2**

The Northern Ireland Prison Service in partnership with the South Eastern Health and Social Care Trust, the Health and Social Care Board and the Department of Health, should urgently review current arrangements to ensure that prisoners suffering from severe mental disorders (including personality disorders, dementia and intellectual disabilities) have equal access to care and treatment in a secure in-patient mental health or learning disability hospital.

The South Eastern Health and Social Care Trust should engage with the commissioners to ensure that future planning for Mental Health provision across Northern Ireland incorporates the needs of the prisoner population, to include agreed pathways for timely access to appropriate hospital beds for those clinically requiring this when experiencing a mental health crisis in a prison setting. The implementation of this recommendation including any actions arising should be overseen by relevant policy leads in the Departments of Health and Justice for consideration by Ministers.

(paragraph 4.42)

STRATEGIC RECOMMENDATION **3**

The Northern Ireland Prison Service, in partnership with Belfast Metropolitan College, within six months of the publication of this report, should ensure that men and women who are held in Care and Supervision Units have equitable access to purposeful activity including learning and skills, library services and physical activity, and that engagement in these activities is proactively encouraged and facilitated.

(paragraph 4.70)

OPERATIONAL RECOMMENDATIONS

OPERATIONAL RECOMMENDATION **1**

The Northern Ireland Prison Service and South Eastern Health and Social Care Trust should ensure that mental health teams along with primary health care are involved in the assessment of all prisoners physical and mental health following their placement in a CSU. This should be implemented within six months of the publication of this report.

(paragraph 2.14)

OPERATIONAL RECOMMENDATION **2**
The Northern Ireland Prison Service should publish its Care and Supervision Unit policy and guidance on its website. This should be completed within three months of the publication of this report.
(paragraph 2.15)

OPERATIONAL RECOMMENDATION **3**
The Northern Ireland Prison Service should ensure that sluice rooms are clean, free of clutter and have sufficient storage capacity and facilities to manage all relevant equipment. All staff should be made aware of the clear function of the sluice and their responsibilities in managing the room effectively. Governance arrangements should be implemented to assure staff practices.
(paragraph 3.8)

OPERATIONAL RECOMMENDATION **4**
The Northern Ireland Prison Service should provide and use appropriate rooms for those in Care and Supervision Units to enable education and association. This should be completed within 12 months of the publication of this report.
(paragraph 3.11)

OPERATIONAL RECOMMENDATION **5**
The Northern Ireland Prison Service should conduct remedial work to improve the current exercise yards at Maghaberry Prison. This should be completed within six months of the publication of this report.
(paragraph 3.16)

OPERATIONAL RECOMMENDATION **6**
The Northern Ireland Prison Service in partnership with Belfast Metropolitan College and North West Regional College service providers, should immediately ensure that learning and skills providers are notified when men and women are transferred to the Care and Supervision Units.
(paragraph 3.63)

OPERATIONAL RECOMMENDATION **7**

The Northern Ireland Prison Service in partnership with Belfast Metropolitan College and North West Regional College service providers, should develop a common and effective recording system for all prisons to share information on Individual Learning Plans and Personal Development Plans to enable all prisoners, including those in the Care and Supervision Units, to continue and progress their learning. This should be completed within six months of the publication of this report.

(paragraph 3.64)

OPERATIONAL RECOMMENDATION **8**

The Northern Ireland Prison Service should immediately start to develop and implement an effective technical solution to record access to basic needs, time out of cell and purposeful activity targets throughout a prisoner's time in a Care and Supervision Unit to provide a complete and instant overview for staff and others, effective audit and external scrutiny.

(paragraph 3.72)

OPERATIONAL RECOMMENDATION **9**

The South Eastern Health and Social Care Trust should ensure that mental health care documentation records the assessed need of the patient and meets professional standards within three months of the publication of this report.

(paragraph 3.75)

OPERATIONAL RECOMMENDATION **10**

The South Eastern Health and Social Care Trust should put in place workforce planning arrangements for accessing out-of-hours mental health crisis response services within three months of the publication of this report.

(paragraph 3.87)

OPERATIONAL RECOMMENDATION **11**

The Northern Ireland Prison Service should review the shared Care and Supervision Unit at Hydebank in line with Rule 11(a) of the Mandela Rules so that men and women are held separately and their individual needs met. This should be done within six months of the publication of this report.

(paragraph 4.21)

CHAPTER 1: INTRODUCTION

BACKGROUND

1.1 Care and Supervision Units (CSUs) are places in prisons in Northern Ireland where some of the most vulnerable, mentally unwell, violent and challenging prisoners are segregated from the rest of the prison population for periods of time. Prisoners who are suspected of concealing drugs or other articles are also held there.

1.2 The Northern Ireland Prison Service (NIPS) estate had three CSUs that served four adult prisons. The CSU at Hydebank Wood had changed to a shared facility in October 2020 that accommodated both women and young men[1] held at Hydebank.

- **Maghaberry Prison, Lisburn** - a modern high security prison housed adult male long term sentenced and remand prisoners, in both separated and integrated conditions.
- **Magilligan Prison, Limavady** - a medium to low security prison held adult male sentenced prisoners who met the relevant security classification.
- **Hydebank Wood Secure College, Belfast** - accommodated young male offenders between 18-24 years of age.
- **Ash House Women's Prison, Belfast** - accommodated all adult female prisoners. It was a stand-alone unit situated within the site at Hydebank in Belfast.

1.3 The Review into the Operation of CSUs in the NIPS was announced by the Minister of Justice, Naomi Long MLA, on 11 November 2020. Criminal Justice Inspection Northern Ireland (CJI) agreed to undertake the Review in partnership with the Regulation and Quality Improvement Authority (RQIA) and the Education and Training Inspectorate (ETI). Her Majesty's Inspectorate of Prisons in England and Wales (HMIP) agreed to undertake a critical review of the draft report.

1.4 CJI, RQIA and HMIP are members of the National Preventive Mechanism, a body established in line with the United Kingdom's obligations under the Optional Protocol to the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

1 At the last full unannounced prison inspection of Ash House Women's prison in 2019, female prisoners were segregated within Ash House.

SCOPE AND METHODOLOGY

1.5 Terms of Reference for the Review were published by CJI on 7 January 2021 (see Appendix 2) with five broad aims. They were to:

- review and assess the effectiveness of strategic oversight and governance arrangements;
- review current policies, practices and procedures relating to CSUs and assess their application and impact on prisoner treatment, well-being and conditions;
- examine and identify outcomes for prisoners relocated to CSUs under Rules 32, 35, 39 and 95[2] and for those not relocated but for whom the same Rules have been applied;
- evaluate the effectiveness of relevant performance management mechanisms; and
- establish how good practice influences continuous improvement, including the implementation of previous CJI inspection recommendations.

1.6 The Review examined the segregation of prisoners using sets of *Expectations* developed by HMIP. The RQIA focused specifically on health care provision using The Quality Standards for Health and Social Care Supporting Good Governance and Best Practice in the Health and Personal Social Services (HPSS). ETI's Inspection and Self-Evaluation Framework underpinned its focus on purposeful activity (education, skills and work activities).

1.7 Supervision Units[3] had been used for many years to segregate men, but it was not until October 2020 that arrangements were put in place to segregate women prisoners in a CSU at Hydebank. Prior to 2020, men were sent to dedicated segregation units while women remained in their own cells, or were relocated within Ash House to another cell or a dedicated landing. While the review focused on the segregation of prisoners in CSUs, this report also considered arrangements for women prior to October 2020.

1.8 It did not include those isolating for COVID-19. It drew on in-depth on-site fieldwork at all four prisons over a three-week period between 25 January and 12 February 2021. Inspectors conducted 52 interviews with 86 staff and 42 prisoners and 13 stakeholder interviews with 34 contributors. Meetings were held with 11 senior NIPS policy and operational leads attached to NIPS Headquarters (HQ). The detailed methodology used for this Review is set out at Appendix 1.

2 *Rule 95 was added to the Terms of Reference during the course of the review as it relates to those held at Hydebank Wood Secure College.*

3 Care and Supervision Unit (CSU) is the current name given to a segregation unit. At the first inspection conducted by CJI in 2005 these units were called Special Supervision Units (SSU).

NORTHERN IRELAND PRISON RULES AND SEGREGATION

1.9 In this report we use the term 'segregation' to describe all situations where adult prisoners are detained in a CSU. The specific Northern Ireland Prison Rules providing the authority to segregate prisoners held at the four prisons were Rule 32(1), Rule 35(4) Rule 39(1) (f)[4], and Prison Rule 95 (2) (f).

- **Rule 32: Restriction of association -** Sub-paragraph (1) - Where it is necessary for the maintenance of good order or discipline (GOOD), 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.
- **Rule 35: Laying of disciplinary charges -** Sub-paragraph (4) - A prisoner who is to be charged with an offence against discipline may be kept apart from other prisoners pending adjudication, if the governor considers that it is necessary, but may not be held separately for more than 48 hours.
- **Rule 39: Governor's awards (including cellular confinement)** Sub-paragraph (1) (f) - The governor may, subject to Rule 41[5], make one or more of the following awards for an offence against prison discipline -
  (a) caution;
  (b) (removed);
  (c) stoppage of earnings for a period not exceeding 56 days;
  (d) stoppage of any or all privileges other than earnings, for a period not exceeding 42 days or 90 days in the case of evening association;
  (e) exclusion from associated work for a period not exceeding 14 days; and
  (f) cellular confinement for a period not exceeding 14 days.
- **Rule 95: Governor's awards** - Rule 39 (1) does not apply to inmates of a young offenders centre. Under Rule 95 (2) (f) a Governor can make an award of confinement to room for a period not exceeding 7 days.

SOLITARY CONFINEMENT AND MEANINGFUL HUMAN CONTACT

1.10 The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) provides '*good principles and practice in the treatment of prisoners and prison management*'. Rule 44 of the Mandela Rules defined solitary confinement as: '*The confinement of prisoners for 22 hours or more a day without meaningful human contact.*'[6]

4 *The Prison and Young Offenders Centres Rules (Northern Ireland) 1995* available at **https://www.justice-ni.gov.uk/sites/default/files/publications/doj/prison-young-offender-centre-Rules-feb-2010.pdf**

5 *Rule 41: Sub-paragraph (2) - No award of cellular confinement shall be given effect unless an appropriate health care professional has certified that the prisoner is in a fit state of health to undergo it.*

6 *United Nations Office on Drugs and Crime, The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)*, December 2015, available at **https://www.unodc.org/documents/justice-and-prison-reform/GA-RESOLUTION/E_ebook.pdf**. See also the definition in Rule 60.6(a) of the *European Prison Rules,* updated July 2020, available at **https://search.coe.int/cm/Pages/result_details.aspx?ObjectId=09000016809ee581**.

1.11 HMIP *Expectations* were designed to promote treatment and conditions in detention that at least met recognised international human rights standards. The indicators to the relevant *Expectations* include that '*prisoners are never subjected to a regime which amounts to solitary confinement…*'. There were separate *Expectations* for men and women and use of segregation was included in both. Inspectors used the HMIP *Expectations* throughout this report.[7]

1.12 Guidance on what constituted meaningful human contact had been provided by a panel of experts convened by the University of Essex and Penal Reform International as follows:[8]

Meaningful human contact - *The term [meaningful human contact] has been used to describe the amount and quality of social interaction and psychological stimulation, which human beings require for their mental health and well-being. Such interaction requires the human contact to be face-to-face and direct (without physical barriers) and more than fleeting or incidental, enabling empathetic interpersonal communication. Contact must not be limited to those interactions determined by prison routines, the course of (criminal) investigations or medical necessity.*

… it does not constitute 'meaningful human contact' if prison staff deliver a food tray, mail or medication to the cell door or if prisoners are able to shout at each other through cell walls or vents. In order for the rationale of the Rule to be met, the contact needs to provide the stimuli necessary for human well-being, which implies an empathetic exchange and sustained, social interaction. Meaningful human contact is direct rather than mediated, continuous rather than abrupt, and must involve genuine dialogue. It could be provided by prison or external staff, individual prisoners, family, friends or others – or by a combination of these.

1.13 The current practice of segregating men and women from their peers in a CSU had potential to become solitary confinement if the prisoner experienced a regime that meets the Mandela Rule 44 definition.

7 *HMI Prisons, Our Expectations,* available at **https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/**

8 *Penal Reform International, Essex paper 3, Initial guidance on the interpretation and implementation of the UN Nelson Mandela Rules, February 2017* available at **https://cdn.penalreform.org/wp-content/uploads/2016/10/Essex-3-paper.pdf**

PRISON INSPECTIONS

1.14 Unannounced prison inspections carried out by CJI in partnership with HMIP, RQIA and the ETI examine all aspects of prison life including the use of segregation and the operation of CSUs. The 2019 CJI Safety of Prisoners report had also reported on conditions for segregated prisoners held in CSUs. It had found that standards at Hydebank Wood CSU had fallen far below that required and described the accommodation as, '*filthy and totally unacceptable*' (later discussed in Chapter 3).[9] Recent inspections carried out in 2017, 2018 and 2019 had identified some improvements but some areas of concern remained about the use of segregation and CSU operations in some prisons, for example:

- the wider criminal justice and health care systems needed to provide alternatives to custody for highly vulnerable prisoners;
- a baseline position for purposeful activity within CSUs needed to be set;
- cleanliness and hygiene had fallen well below acceptable standards and needed to be maintained;
- reasons why prisoners are retained in segregation after passive drug dog indications needed to be recorded and justified;
- some men were spending long periods in the CSU;
- in the absence of a female CSU, some women spent long periods in segregation within Ash House; and
- some women were segregated while at risk of self-harm within Ash House.

1.15 An unannounced prison inspection of Magilligan was conducted by CJI, HMIP, RQIA and ETI during May and June 2021. This report will be published in the near future.

9 *CJI, The Safety of Prisoners held by the Northern Ireland Prison Service, November 2019* available at **http://www.cjini.org/getattachment/3a70dd41-7bb3-430d-9901-3ed7a191cf94/report.aspx**

CHAPTER 2: STRATEGY AND GOVERNANCE

2.1 This chapter deals with the NIPS corporate strategy underpinning the operation of CSUs and corporate oversight arrangements. Processes for overseeing delivery at each prison are discussed in Chapter 4.

STRATEGIC APPROACH

2.2 The NIPS had no stated vision for CSUs or corporate framework underpinning their operation. This had resulted in a lack of cohesive operational delivery across the three CSUs.

2.3 A strategy was required to provide clarity in vision and future direction, for example:

- corporate responsibility aligned to policy and practice;
- the physical environment (including infrastructure, facilities and technology);
- staff selection, training and welfare;
- technology to support and enhance delivery;
- provision and delivery of services;
- provision and delivery of learning, skills and activities;
- effective strategic oversight arrangements (corporately and local); and
- provision of effective management information.

CORPORATE OVERSIGHT BY THE NIPS

2.4 There was no routine monitoring or analysis of data on the use of segregation to direct and improve strategic management of these areas.

2.5 NIPS HQ had access to a Governing Governors Daily Report that contained details of segregated men and women prisoners on a specific day only. The report was helpful to Governing Governors but contributed little to understanding wider trends for the purposes of oversight and governance at a corporate level.

2.6 The following example helped to demonstrate this point: the Prison Rules required the agreement of the Department of Justice (DoJ) to extend segregation of all prisoners held under Rule 32 beyond 72 hours. The authority to provide 'agreement' had been delegated by the DoJ to NIPS HQ.

2.7 The Governing Governors Daily Report provided no insight on these arrangements or what impact they had. Requested data on the total number of applications for Rule 32 extensions was not recorded by the NIPS. The lack of this data meant the NIPS could not demonstrate adequate oversight of extension decisions.

Operational Management Board (OMB)

2.8 The OMB oversaw the NIPS delivery of its operational responsibilities. Inspectors examined the minutes of OMB meetings for the period April 2019 to November 2020 and spoke to those attending the Board to understand what oversight it had of CSUs. The minutes and interviews indicated that the OMB played a minimal role in the strategic oversight of CSU operations. The OMB did not review any performance data in relation to CSUs and there had been no discussion of CSU performance. For the entire period examined, CSUs were only mentioned on two separate occasions (this related to work at Hydebank Wood). As the result of this, Inspectors found that outcomes for those in CSUs were not adequately monitored.

STRATEGIC RECOMMENDATION 1

The Northern Ireland Prison Service should develop a vision, strategy and action plan for the effective operation of Care and Supervision Units within nine months of publication of this report and incorporate the following:

- a framework for the operation of Care and Supervision Units which reflects minimum standards for the treatment of prisoners held in segregation including guidance on the interpretation of 'meaningful human contact';
- a plan for the development of Care and Supervision Unit accommodation and facilities to support effective delivery and improved outcomes for prisoners modelled on the design principles underpinning the Care and Supervision Unit at Hydebank Wood and of Davis House;
- in collaboration with the Department of Justice, a review of Rule 32 policy, guidance and audit of practice, care and reintegration planning;
- effective arrangements for governance, audit and oversight of those held in Care and Supervision Units including the development of relevant data capture methods and management information to meet Northern Ireland Prison Service and Department of Justice assurance needs; and
- processes to select, train and support staff and managers working in Care and Supervision Units including clinical supervision.

2.9 Inspectors examined policy and practice guidance relevant to the operation of CSUs by the NIPS that included the following:

- **Prison Rule 32** - The application of Prison Rule 32 was contained in a NIPS policy and guidance instruction published in 2013 and provided advice to Governors and DoJ representatives;
- **Prison Rule 35(4)** - Instruction to Governors (IG 02/13) was published by the NIPS in 2013 and provided guidance to managers on procedures for the application of Prison Rule 35(4); and
- **Prison Rule 39(f) (CC)** *[Cellular Confinement]* - Prison Rule 41(2) stated that, '*No award of CC shall be given effect unless an appropriate health care professional has certified that the prisoner is in a fit state of health to undergo it*'. The current Instruction to Governors (IG 04/18), was published in 2018 and provided guidance to managers on procedures relating to a prisoner's fitness for adjudication when applying Prison Rule 39.

2.10 A NIPS Instruction to Governors provided the policy on '*Fitness for Adjudication*' (IG 04/18) and stated, '*From 02 July 2018 South Eastern Health and Social Care Trust (SEHSCT) staff will no longer 'fit' prisoners for adjudication*'. Inspectors were told that this was because the SEHSCT no longer wished to be involved in a punitive process that was not in keeping with the overall principles of patient-centered care in prisons. Inspectors noted that the new procedure as set out in IG 04/18 was in breach of Prison Rule 41(2).

2.11 IG 04/18 also stated that, '*Following an award of cellular confinement, the individual will be seen by prison health care staff within 2 hours for assessment of their immediate health care needs*.' Inspectors examined the Standard Operating Procedure (SOP) PH/PCMH/P01 published by the SEHSCT in 2018 that provided instructions to health care staff on the procedure for all prisoners held in CSUs. The effect of this was that an assessment was conducted only after a period of cellular confinement had been imposed. The SOP was being updated at the time of this Review.

2.12 The current process was that the 'adjudicator' (a Prison Officer normally a Governor grade) made the decision about a prisoner's fitness to participate in the adjudication process. Inspectors found that guidance stating that the adjudicator 'may' take into account advice provided by a health care professional did not sufficiently safeguard prisoner health care considerations. The policy also stated that, '*The Adjudicator must consider any contra clinical evidence presented that the prisoner may not be fit to undergo the adjudication at that time*.' Inspectors did not find the policy to be clear from whom 'contra clinical evidence' was to be sought or how this was presented when making a decision.

2.13 The current policy failed to provide clarity on the process and role of health care professionals in decisions about fitness to participate in adjudication proceedings. In the event that a prisoner was deemed 'fit', the policy provided no guidance on how health care was involved once an 'award' for cellular confinement was made and what role they had before the prisoner was segregated in a CSU.

2.14 Current practice did not provide assurance to ensure that a prisoner's physical and mental health had been adequately reviewed prior to an adjudicator segregating a prisoner in a CSU. Data was not available on how the changed procedure resulted in better or poorer outcomes for prisoners. Prisoners not known to mental health services were not assessed during their time in the CSU.

OPERATIONAL RECOMMENDATION 1

The Northern Ireland Prison Service and South Eastern Health and Social Care Trust should ensure that mental health teams along with primary health care are involved in the assessment of all prisoners physical and mental health following their placement in a CSU. This should be implemented within six months of the publication of this report.

2.15 Policy and practice guidance relating to the operation of CSUs did not appear on the nidirect website (Government website for Northern Ireland), or on the DoJ website. Inspectors have identified an opportunity to increase greater public access to information and transparency.

OPERATIONAL RECOMMENDATION 2

The Northern Ireland Prison Service should publish its Care and Supervision Unit policy and guidance on its website. This should be completed within three months of the publication of this report.

Continuous improvement

2.16 Inspectors were told that there had been no formal evaluation of the new Hydebank CSU since it opened in 2019 to assess and measure the outcomes for the prisoner population and staff. This indicated to Inspectors that there is no sharing of lessons learned or good practice across the sites.

2.17 Inspectors were told by Governors that there was an opportunity for better information sharing with colleagues in the other prisons. When Governors and other staff transferred between one prison and the other, they brought with them elements of good practice, which they sometimes implemented. Inspectors found that this is not a co-ordinated approach to continuous improvement across the prison estate.

CHAPTER 3: DELIVERY

3.1 This Chapter sets out a description of CSUs at each site and the facilities within them, the types of prisoners held in CSUs and how they operate on a day-to-day basis. This includes information about the processes of entering and exiting CSUs, how periods of segregation are managed, daily routines, purposeful activity, health care services and the selection, training and support for staff working in CSUs.

CSU AND THE FACILITIES WITHIN THEM

3.2 CSUs were self-contained residential units within each prison. At Maghaberry the CSU accommodation was on two floors each of which had two landings. In general, prisoners progressed from the lower to the upper landings. At Magilligan, the CSU was a stand-alone unit comprised of two landings on a ground floor. During fieldwork, one was generally used for those placed in cellular confinement and the other held those who had been placed on Rule 32. At Hydebank all male prisoners were held on one landing and four cells on an adjacent landing were allocated to female prisoners. Women 'awarded' cellular confinement or who had been placed on Rule 35(4) generally remained in Ash House.

3.3 CSUs accommodated up to 64 prisoners (60 male and four female prisoners) in total. Maghaberry had the largest unit and held up to 30 prisoners and Magilligan and Hydebank held up to 14 and 20 prisoners (16 male and four female) respectively. The nature of the accommodation and associated facilities varied at each site (see Appendix 5 for further detail).

3.4 Cells in Maghaberry CSU were generally bright, at a satisfactory temperature and well ventilated. Some fixtures, fittings and furnishings were worn throughout and needed to be replaced. Two 'dry' cells were bare unfurnished cells that did not contain normal furniture, fittings, bedding or clothing. Both were sparse and the one that was unoccupied was very cold. A prisoner told Inspectors that the dry cell he had been in was the coldest cell in the jail.

3.5 Prisoners were responsible for cleaning their own cells. Orderlies cleaned communal areas and paid contractors were used as necessary. The standard of cleaning was generally good.

3.6 Storage facilities within Maghaberry CSU were limited and some areas were cluttered. Reusable personal items, such as bedpans, were found on the bottom of the tea trolley and in a storeroom that contained cleaning materials, clean linen, paint and the used linen trolley. There was a strong odour in the room allocated to washing bedpans and there was a build-up of material in a sluice system used to facilitate the detection of foreign items in bodily waste. The storage facilities were inadequate and cleaning of the areas was unacceptable and required effective governance arrangements.

Photograph 1

Trolleys in use at Maghaberry

Photograph 2

Trolleys in use at Maghaberry

Photograph 3

Storeroom sluice sink at Maghaberry

Photograph 4

Sluice system at Maghaberry
(for detecting objects in bodily waste)

3.7 Fixtures and fittings in Magilligan CSU were well maintained. Inspectors were shown examples of new furniture in one cell. The standard of cleaning was excellent throughout the CSU and effective governance arrangements were in place. The environment was well ventilated and the temperature was satisfactory.

Photograph 5

Landing 'A' in Magilligan CSU

3.8 The CSU at Hydebank had opened during 2019. A recent unannounced full inspection by CJI and partners had acknowledged the significant improvements and important changes in approach being provided by a new CSU facility.[10] The CSU was a bright, vibrant and a calming place. There was good use of colour and acoustics. The standard of cleanliness was evident throughout the unit.

OPERATIONAL RECOMMENDATION **3**

The Northern Ireland Prison Service should ensure that sluice rooms are clean, free of clutter and have sufficient storage capacity and facilities to manage all relevant equipment. All staff should be made aware of the clear function of the sluice and their responsibilities in managing the room effectively. Governance arrangements should be implemented to assure staff practices.

10 *CJI, Report on an unannounced inspection of Hydebank Wood Secure College, June 2020* available at **http://www.cjini.org/getattachment/f29852c3-e432-4f16-b9f5-51fe15710792/report.aspx**

Photograph 6

Entrance to the CSU at Hydebank

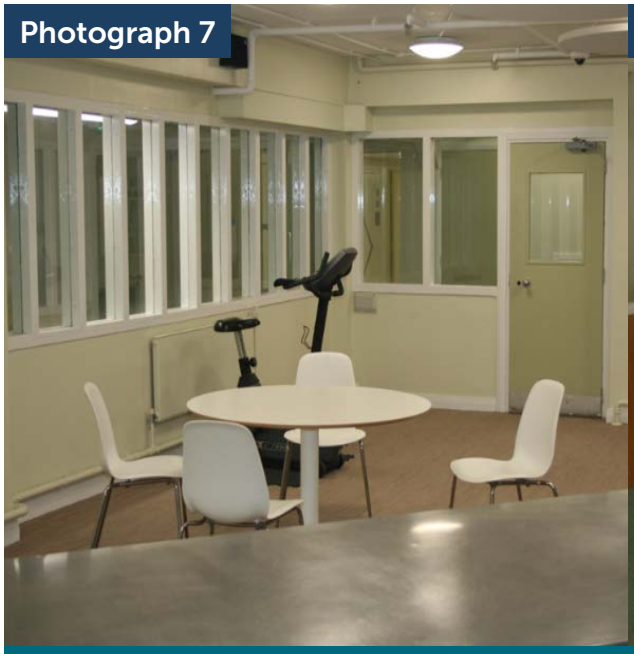
3.9 Prisoners in all cells in all CSUs had 24-hour access to the Samaritans. There were restrictions on the amount of personal property that prisoners were permitted in their cells. At Maghaberry, items not permitted in the cell were placed outside the cell door and prisoners could request access to these items as required. The amount of property prisoners were permitted was determined locally and was influenced by how long prisoners were in the CSU and the assessment of risk.

3.10 Each CSU had a small number of special accommodation cells and their use required the authorisation of a Governor. These included two dry cells at Maghaberry, observation cells for those deemed at risk of self-harm or other reasons as specified in Prison Rule 47/48A[11] and other cells that were used to recover unauthorised or prohibited articles (see Appendix 5). Hydebank had a de-escalation (sensory) room fitted with acoustic panels to reduce noise intrusion that was painted with calming colours. It contained moveable furniture to provide a sense of individual control. It was only used for short periods prior to prisoners being placed in normal or special accommodation.

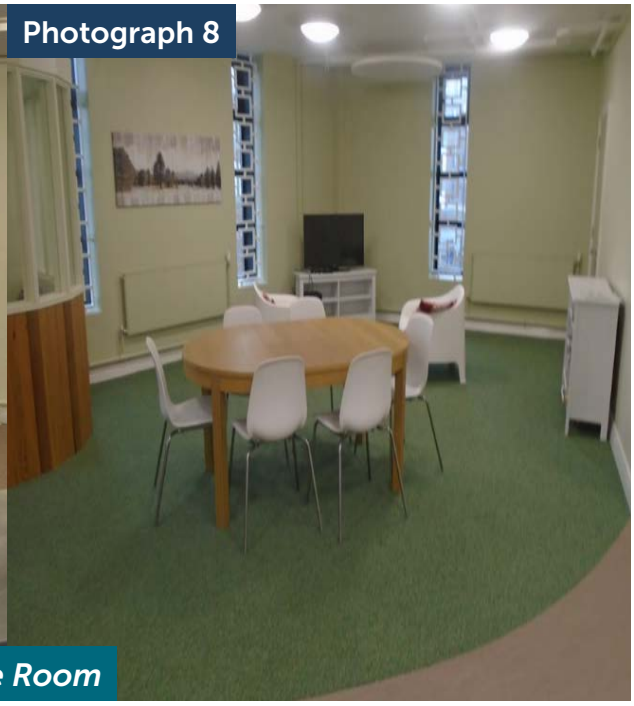
3.11 Unlike normal residential units/areas, there were no communal rooms or areas for dining, associating with other prisoners or classrooms within the CSUs at Maghaberry and Magilligan. There were limited interview rooms to facilitate one to one discussions with prisoners. This issue was raised with Inspectors by several stakeholders. This was in contrast to Hydebank where there was a multi-purpose room equipped with seating, television, game console, exercise bike, small library and servery facility. This room was bright, airy and had the potential to support purposeful activity, including learning and skills.

11 *The Prison and Young Offenders Centres Rules (Northern Ireland) 1995* available at **https://www.justice-ni.gov.uk/sites/default/files/publications/doj/prison-young-offender-centre-Rules-feb-2010.pdf**

Photograph 7



Photograph 8



Facilities in the Hydebank Multi-Purpose Room

OPERATIONAL RECOMMENDATION 4

The Northern Ireland Prison Service should provide and use appropriate rooms for those in Care and Supervision Units to enable education and association. This should be completed within 12 months of the publication of this report.

3.12 Prisoners could access telephones on the landings. Telephone booths at Maghaberry and Hydebank afforded prisoner's privacy and seating was provided in the booth at Hydebank (see Photograph 8). During fieldwork at Magilligan CSU, the telephones were on the landing and provided no privacy whatsoever.

3.13 Visiting facilities for those in the CSU were the same as the general population. During fieldwork, the prisoners were attending virtual visits. Due to the COVID-19 pandemic, video link technology had been installed in a number of residential units in prisons to facilitate visits and other meetings. Those arrangements had not been extended to CSUs. There were no plans to do so at Maghaberry, but there was evidence that work was underway to install units at Magilligan and Hydebank CSUs.

3.14 Each CSU had a dedicated exercise yard(s) to facilitate outdoor exercise. These were enclosed hard surfaced areas surrounded by razor wire. There was some fixed exercise/recreation equipment in each yard and limited seating. The two yards at Maghaberry were smaller compared to those at the other two sites and were grey, oppressive spaces. Remedial work should be undertaken as soon as possible to improve the current yards at Maghaberry CSU.

Photograph 9

Exercise yard at Maghaberry CSU (picture one of two)

Photograph 10

Exercise yard at Hydebank CSU (picture two of two)

3.15 In contrast, Magilligan's CSU had developed a separate outdoor sensory garden and was the only one of its kind attached to a CSU. The garden was developed with help from the horticulture tutor and prisoners. Although also heavily dominated by the presence of razor wire, it provided a better therapeutic open space. At Hydebank, there was secure access to an area with animals but the existing yard needed to be further developed.

Photograph 11

Outdoor sensory garden at Magilligan CSU

3.16 Exercise equipment was available in each CSU. There was a good internal gym at Maghaberry but access to it was very limited. At Magilligan and Hydebank CSU, some exercise equipment was available on landings only (use of these facilities is discussed later in the report).

OPERATIONAL RECOMMENDATION 5

The Northern Ireland Prison Service should conduct remedial work to improve the current exercise yards at Maghaberry Prison. This should be completed within six months of the publication of this report.

Who is held in the CSUs and why are they there?

3.17 On commencing fieldwork, 11 male prisoners were segregated in the CSUs. This included one who had been held for 366 days. There were no female prisoners in the CSU at Hydebank although one female prisoner was sent to the Unit for segregation during our visit.

3.18 Data[12] for the period 2011 to 2020 showed that the average population of Maghaberry and Magilligan CSUs was 2% of the respective average daily populations. At Hydebank Wood the proportion was 4% of the average daily population. Until 2019, the average population of the Hydebank CSU was four prisoners, but this increased to seven in 2019 and increased further to 11 in 2020. Recent prison inspections by CJI and its partners had identified that the level of segregation of male prisoners was higher than Inspectors normally found in England and Wales.

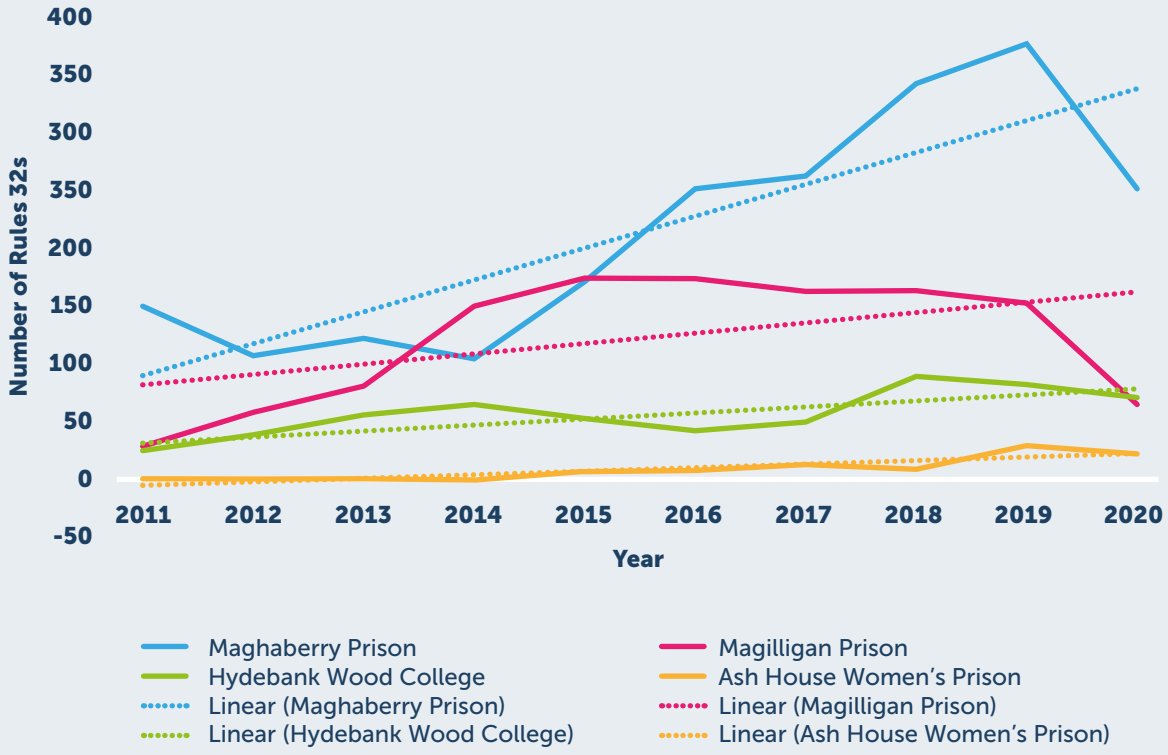
12 The following data was provided by the NIPS. For the period 2011 to 2020 at Maghaberry the average daily population of the CSU was 19 and the average daily prison population was 937. At Magilligan the average daily population of the CSU was seven and the average daily prison population was 486. At Hydebank Wood (male) the average daily population was four and the average daily prison population was 128.

3.19 In the last inspection of Ash House Women's Prison by CJI and its partners, Inspectors found that levels of segregation of female prisoners was not excessive. Inspectors were unable to assess the use of the CSU for female prisoners as the joint facility at Hydebank had only recently opened (see findings at Chapter 4 in relation to women).

Use of Rule 32

3.20 Prisoners were segregated under Rule 32 when it was necessary for good order or discipline, to ensure the safety of themselves and others or in their own interests. From 2014 to 2019, there was a steady increase in the use of Rule 32 at Maghaberry where the number of committals[13] had more than tripled from 104 (2014) to 378 (2019). Rule 32s had continued to increase at the other two prisons over the same period (see Chart 1). During 2020, the application of Rule 32 had reduced for a number of reasons including the introduction of a 14 day quarantine for all prisoners entering custody. The NIPS advised that this measure directly related to a reduction in trafficking into prisons.

Chart 1: Initial Rule 32s granted by establishment (1 January 2011 to 30 November 2020)



13 Under reason for committal an individual may be counted more than once if they have been committed to the CSU on different occasions for different reasons.

3.21 From 2017, the increased application of Rule 32 corresponded with more robust action being taken by establishments to disrupt the supply of drugs and other prohibited articles coming into prisons. Inspectors previously reported[14] that this approach had resulted in a degree of success in reducing the supply of drugs into prisons, however, the continued application of this strategy resulted in an increased number of prisoners being segregated and this was not a positive outcome for those prisoners. There is further discussion on the use of body scanners in Chapter 4.

3.22 Since 2011, the average duration of stays in the CSU at Maghaberry had reduced from 99 days to 16 days in 2020. This was a significant improvement. Over the same period, the average duration at Magilligan remained consistent at 10 days. The robust approach adopted by the NIPS to reduce the supply of drugs in prisons had impacted on the average duration of stays at Hydebank and had increased from nine days in 2017 to 14 days for males in 2020 and from five days in 2017 to 12 days for females in 2020.

3.23 From 2015, the use of drug recovery cells had increased but had reduced in 2020 due to the pandemic. The average duration of stays in drug recovery cells ranged from two to seven days. Some individuals spent excessively long periods segregated in these cells. In 2018, one individual spent 69 days in a drug recovery cell at Magilligan. In 2020, the maximum length of time a prisoner spent in a drug recovery cell at Maghaberry was nine days, compared with 22 days at Magilligan and 14 days at Hydebank.

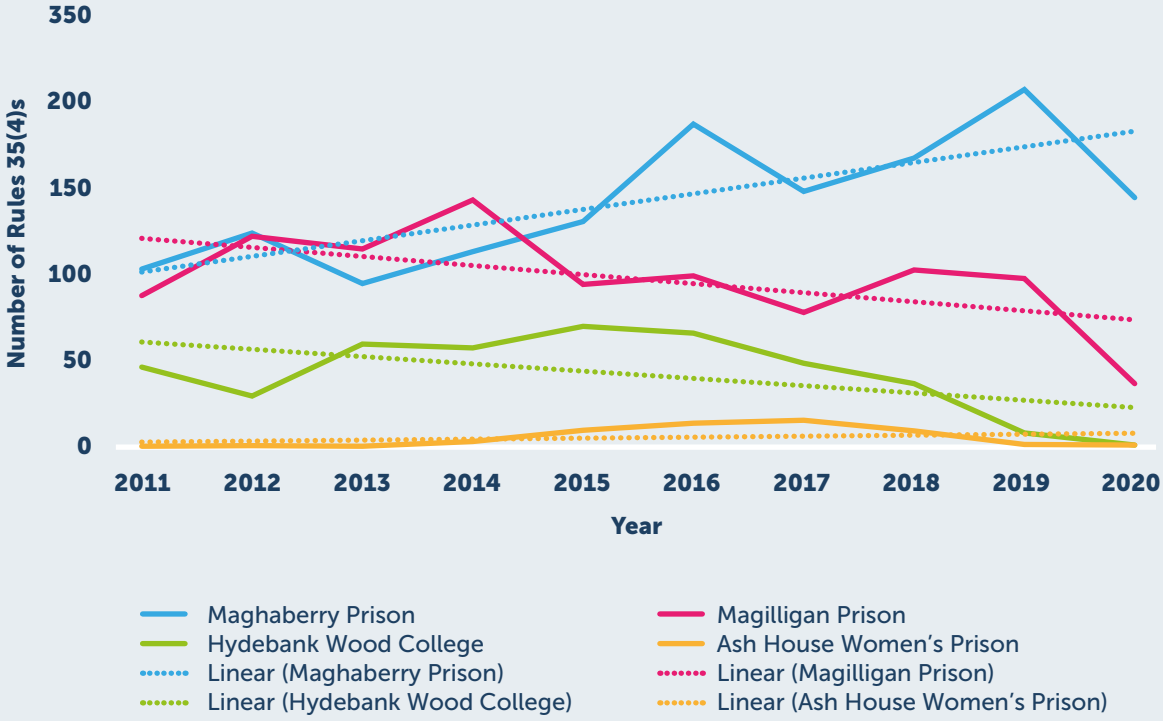
3.24 Dry cells were unique to Maghaberry CSU and provided the most basic accommodation in the CSU. From 2015 the average duration of stays in dry cells at Maghaberry was three days, but there were individual examples of prisoners spending excessively long periods in dry cells. In 2020, some prisoners had spent 25 days and 16 days in dry cells. Such cells should only ever be used as a last resort and for the shortest time possible.

Use of Rule 35(4)

3.25 Rule 35(4) was used to segregate prisoners pending adjudication. From 2011, use of Rule 35(4) varied between establishments. An overall trend showed a steady increase in the number of times Rule 35(4) was used at Maghaberry while at the other establishments the overall trend was a decreasing one (see Chart 2). The average duration of stays under Rule 35(4) was two days. This was proportionate to the maximum time that someone could be held under this Rule.

14 *CJI, The Safety of Prisoners held by the Northern Ireland Prison Service, November 2019,* available at **http://www.cjini.org/getattachment/3a70dd41-7bb3-430d-9901-3ed7a191cf94/report.aspx**

Chart 2: Rule 35(4s) granted by establishment (1 January 2011 to 30 November 2020)



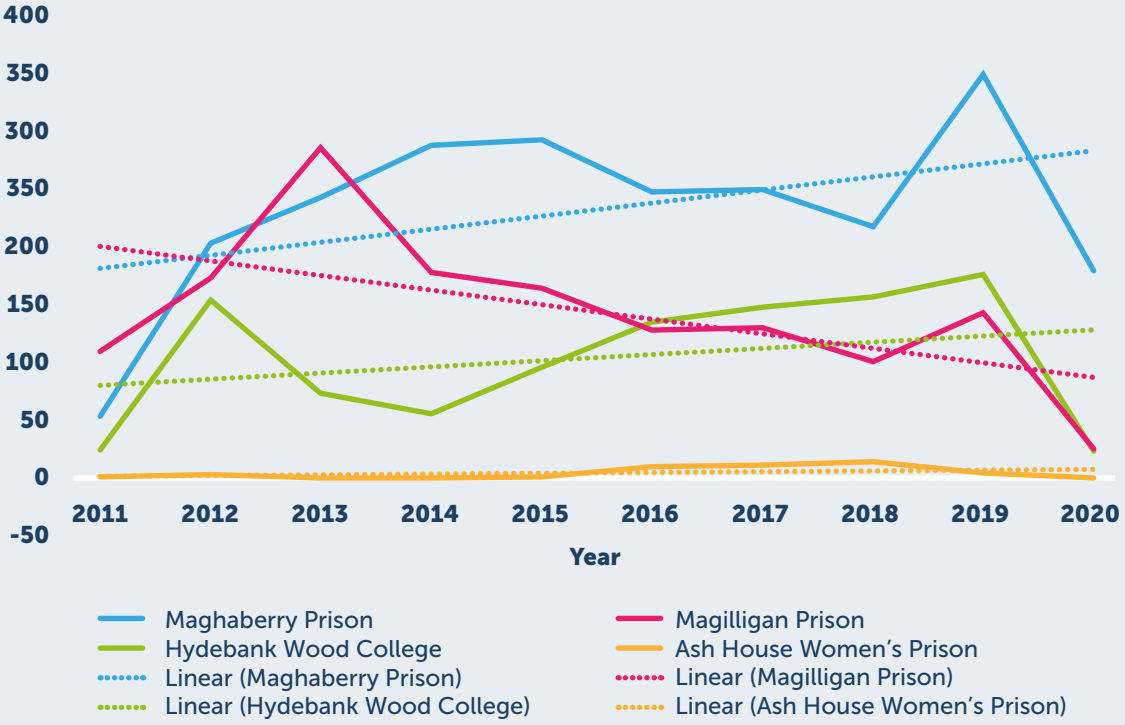
Use of cellular confinement

3.26 Cellular confinement was one of a number of punishment outcomes that was 'awarded' following the adjudication hearing. The top reason for this 'award' was possession of 'unauthorised articles' (data for 2015 to 30 November 2020).[15] This was generally consistent across each prison at just under 30% (1,028 of 3,527) of all 'awards'. The 'presence of drugs' was the second highest reason for the use of cellular confinement and was 'awarded' in around 25% (380 of 1,539) of cases at Magilligan but just 5% (44 of 867) of the cases at Maghaberry. The disparity of use needed further analysis by the NIPS.

3.27 Use of cellular confinement was consistently higher at Magilligan than the other prisons. Data showed that there was an upward trend at Maghaberry and Magilligan between 2011 and 2019 (2020 excluded because of the COVID-19 pandemic). Data also confirmed that cellular confinement was used sparingly for women at Ash House. At Hydebank Wood the instances of use for young men was on par with Maghaberry until 2016. Proportionately, since then, it was far higher than both Maghaberry and Magilligan. Data suggests that cellular confinement was not being used as a last resort with use at Magilligan and Hydebank being particularly high. Inspectors identified that data was not monitored or used effectively to strategically identify organisational trends nor to implement actions to mitigate excessive use.

15 NIPS *unpublished data*

Chart 3: Instances where cellular confinement was 'awarded' – 1 January 2011- 31 December 2019



Entering the CSU

3.28 Regardless of why segregation was authorised, the pathway into a CSU followed a similar process. A chart showing a high-level summary is included at Appendix 4.

3.29 Inspectors found that the Rule 32 paperwork reviewed lacked evidence of consideration of other alternatives to segregation, despite this being a mandatory requirement of the NIPS policy[16].

3.30 The quality of the records of Governor's interviews conducted prior to authorising segregation on Rule 32 were inconsistent. Some had detailed accounts of the discussion and included exploration of the reason for the behaviour while others provided only a brief account of the discussion. Inspectors found that in most of the documents, the reasons for segregation were not routinely documented as required.

3.31 Rule 35(4) documentation mostly contained a brief description of the alleged breach of prison rules and adjudication paperwork but did not explain the rationale behind a Governor's decision to 'award' cellular confinement under Prison Rule 39. Feedback from prisoners was consistent with what Inspectors found. Records need to contain greater detail along with evidence that prisoners fully understand the rationale for decisions to segregate in a CSU.

16 *NIPS, Application of Prison Rule 32, Policy & Guidance to Governors and Dept of Justice Representatives 2013*. Unpublished, Internal Document.

3.32 Health care was informed when a prisoner arrived in a CSU. Records showed that the Independent Monitoring Board (IMB) members were not always informed within 24 hours that a prisoner had been placed on Rule 32. Inspectors found that an initial health assessment was conducted within two to four hours of their arrival. A health care prisoner algorithm was used at Magilligan for those to be segregated for more than four hours but it was not used at the other prisons. An Expert Review Team when conducting fieldwork for the '*Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons*', reported that, '*A similar algorithm should be developed and implemented in Northern Ireland*'.[17] HMIP's *Expectations* for Women state that a safety algorithm should be completed by a member of health care staff within two hours of segregation. Inspectors agree that algorithms,[18] similar to those used at Magilligan, should be implemented for men and women held in all CSUs.

3.33 The report also noted that all prisoners in the CSU were reviewed by the Primary Care Team within two hours. Inspectors learned that the SEHSCT planned to increase the initial health screen from two to four hours in line with the community model. The report on *Services for Vulnerable Persons Detained in Northern Ireland Prisons* also stated that, '*The prison mental health stepped-care approach is perceived to offer equivalence to provision within the community as it is essentially the same model of care. It should be noted that the principle of equivalence pertains to offering the same standard and quality of healthcare but does not require the service model to be identical.*' Inspectors are opposed to a prison model of care that effectively doubles the current review period from within two hours to between two and four hours.

3.34 Inspectors were encouraged by the efforts of staff at Magilligan CSU who had recognised the need to bring together relevant information to help assess and support prisoners while segregated in the CSU. The Prisoner Booklet they had developed was used for all prisoners arriving into the Unit. This approach should be developed further and should consider use of an IT solution (see paragraph 3.72).

Rule 32 review, oversight and local governance arrangements

3.35 Rule 32 reviews were required 72 hours after the initial decision to segregate a prisoner or before the expiry of any extended period. Applications to extend the period of segregation had been conducted on a timely basis and within the appropriate timescales.

3.36 Reviews were conducted using a template issued by HQ to guide discussions and completion. Case conferences were chaired by Duty Governors and were normally attended by a CSU Senior Officer, a Senior Officer from the security department and a representative of the IMB. Chaplains and representatives of Prisoner Safety and Support Teams (PSST) attended some meetings. Health care did not attend initial Rule 32 case conferences and did not routinely provide input to them.

17 *RQIA, Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons, October 2021,* available at **https://www.rqia.org.uk/RQIA/files/95/955cfa4a-5199-4be7-9f1a-801e1369ce84.pdf**

18 An algorithm is a set of instructions for solving a problem or accomplishing a task.

3.37 Overall IMB members reported that Governors and staff were responsive to issues raised by them. During the pandemic IMB members did not attend Rule 32 reviews for a period and arrangements were made to review documentation away from CSUs. This directly impacted on their ability to scrutinise Rule 32 review decisions, as they could not engage directly with participants in the process, including prisoners.

3.38 When IMB members had concerns about decisions taken at Rule 32 case conferences, they recorded this on the Rule 32 papers. Inspectors saw two cases where the IMB had documented objections to the continued detention of two individuals due to concerns about the detrimental impact of further extended periods of detention in a CSU. In both cases, the HQ Governor noted the concerns raised by the IMB but had extended the period of segregation.

3.39 Requests to extend segregation periods under Rule 32 were agreed by a HQ Governor who fulfilled the role of the independent Authorising Officer on behalf of the DoJ (see paragraph 2.6). An extension could be agreed for up to one month (28 days or four calendar weeks). These were conducted in a timely manner. However, the quality of these reviews varied. Some provided detailed written accounts of information, reviewed the discussion with the prisoner and outlined the reasons for the agreement. Others outlined details of behaviour(s) that would contribute to an end of segregation. This was seldom reflected in exit and reintegration plans. When a full extension period was not granted, the rationale behind this was not routinely explained on the documentation reviewed by Inspectors.

3.40 A Rule 32 case conference was observed at each prison. Discussions of the cases were often brief and largely focussed on what had happened rather than the underlying cause of the behaviours that had resulted in the individual being segregated. Wider contributions were mostly restricted to the information that service providers already held on prisoners. Prisoners attended in person or provided written input and Inspectors saw examples of cases where staff recorded the prisoner's input. Prisoners interviewed by Inspectors were mostly negative about how their contribution influenced the decisions taken at case conferences. One prisoner said: *".....it doesn't matter what you say, they will keep you there anyway."* Prisoners felt that the reviews were procedural with predetermined outcomes.

3.41 Existing arrangements for Rule 32 case conferences lacked multi-disciplinary input and should include health care. When it is not practical for health care to attend, it is essential that relevant information is available to Governors chairing case conferences.

Prison oversight of Rule 32s

3.42 Mechanisms had been developed by prisons to enhance the Rule 32 monitoring process. This included the introduction of an oversight meeting at each establishment and a weekly review meeting at Maghaberry.[19] There was no corporate policy or terms of reference for the meetings although Hydebank had developed its own terms of reference.

3.43 Oversight meetings took a different form at each prison. When first introduced at Maghaberry they were well attended and contributions had resulted in a much stronger focus on individual care planning. Maghaberry now held a monthly meeting to consider selected cases, Magilligan held them as required and Hydebank held its meeting on a weekly basis. At Magilligan and Hydebank, they were chaired by the Deputy Governor and at Maghaberry chaired by the Functional Head of Residential and Safer Custody.

3.44 Unlike Rule 32 case conferences, oversight meetings had greater multi-disciplinary input/attendance although again the conduct and input to these meetings had been impacted during the COVID-19 pandemic. All meetings required input from a range of disciplines including health care and mental health, Alcohol and Drugs: Empowering People through Therapy (AD:EPT), Prisoner Development Unit (PDU), PSST and CSU residential staff. There were gaps in contributions, for example, from learning and skills and psychology staff. Both had significant contributions to make and should contribute to this process.

3.45 At Rule 32 case conferences, Primary Health Care and Mental Health Care did not routinely attend and written input reviewed by Inspectors provided little detail. Should health care be unable attend, it is essential that relevant information is provided. Input from speech and language therapists to meetings at Hydebank were considered very valuable by Governors and other service providers. Inspectors found evidence of meaningful contributions made by the speech and language therapist to improve outcomes for those in a CSU. For example, the therapist had been proactive in developing communication aids to support those in the CSU to aid understanding of the regime and to promote engagement. Inspectors consider that Maghaberry and Magilligan would benefit from a similar service.

3.46 Inspectors observed a Rule 32 oversight meeting at each prison and reviewed a selection of minutes of previous meetings. There was clear focus on individual needs and provision of care and support at Hydebank's meetings. There was evidence of relevant contributions to the meeting as well as helpful, detailed reports provided by the CSU residential staff. There was a clear distinction between oversight and Rule 32 review meetings at Hydebank; this was not so evident at Maghaberry and at Magilligan Inspectors could see no difference. A weekly review introduced at Maghaberry was not adding value in terms of outcomes for those in the CSU.

19 *In 2018, leave for making an application for Judicial Review was granted regarding a challenge to continued detention under Rule 32. While the matter did not proceed to a full hearing, during the course of the leave hearing the Judge did query if there was any intervening informal review within the Rule 32 extension period. Due to the matter not proceeding to a full hearing there was no verbal or written judgement, however the NIPS did take into account the judicial comments regarding an additional informal review mechanism within a Rule 32 extension period resulting in the introduction of the weekly meeting at Maghaberry.*

3.47 Prisoners did not attend oversight meetings at Hydebank or Maghaberry but could provide written input to them. At Magilligan, prisoners attended at the end of the meeting and were advised of the outcome of the discussions. Inspectors observed open and meaningful engagement between the prisoner and meeting participants to plan his exit from the CSU. To promote openness and transparency, all prisoners should be given the opportunity to attend oversight meetings in person.

3.48 Minutes of oversight meetings were reviewed and Inspectors found that actions were not always carried over to the next meeting. In one case, a young man was unable to read or write. Recommendations by the oversight meeting on day two of his detention identified this issue but there no evidence at subsequent reviews of follow-up to a resolution. On the 51st and 59th day of detention, the Learning and Skills Manager was to visit the prisoner but there was no evidence of that having occurred or that it was followed up. The Rule 32 period of segregation ended on day 60.

3.49 Senior managers at each prison used data to monitor the use of segregation. Hydebank had more comprehensive monitoring arrangements in place compared with the other two prisons and held a weekly Operational Safety meeting at which trends for the previous six months were examined. Inspectors recognised the benefits of having this data but saw no evidence of how its use had improved outcomes for prisoners.

3.50 Maghaberry had commenced a new monthly Rule 32 audit but it largely focussed on procedural practice rather than on improved outcomes for prisoners.

3.51 The existing NIPS application of Rule 32 policy no longer reflected current oversight and review practice that operated across the prison estate and this needed to be reviewed and updated (see Strategic Recommendation 1).

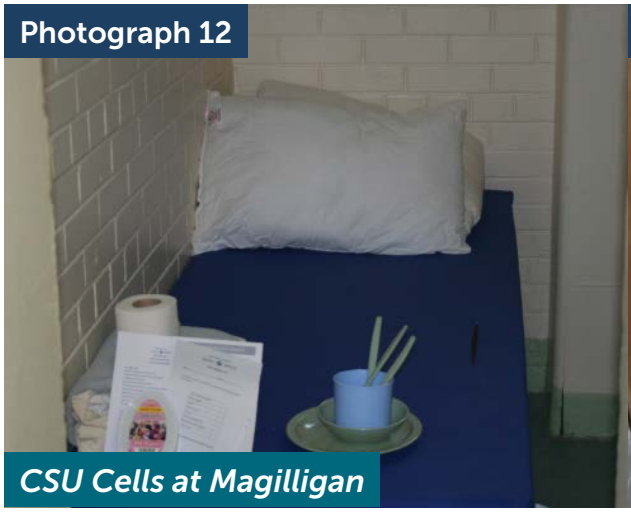
REGIME AND PURPOSEFUL ACTIVITY

Daily regimes

3.52 Each CSU operated similar daily routines for weekdays and weekends. When not showering, attending the exercise yard, using the telephones or attending other appointments such as visits or health care, prisoners were locked in their cells. In-cell and out of cell activities available to prisoners in CSUs were restricted and curtailed by both the regime and the environment. There was limited if any distinction in regime based on the reasons prisoners were held in a CSU. One prisoner told Inspectors, *"Rule 32 [is the] same as CC but [you] get a TV."*

3.53 All meals were given at cell doors and eaten in cells containing either toilets, chemical toilets or bedpans. There were no dining facilities for prisoners to eat meals outside of their cells except at Hydebank; when Inspectors visited, even here, meals were still being eaten in cells. Inspectors expect prisoners to have the opportunity to eat their meals outside of their cells.

Photograph 12



Photograph 13

CSU Cells at Magilligan

3.54 When unlocked in the morning, prisoners were asked if they wanted to shower, use the outdoor exercise yard, telephone or make any other requests. At Maghaberry CSU staff kept daily request sheets and recorded 'Requests' for showers, use of the exercise yard or to make telephone calls. At Magilligan and Hydebank, this information was recorded in landing journals with a tick indicating what had been requested. If a prisoner used the telephone several times then additional ticks were added. In both journals and on request sheets some entries were left blank so it was unclear whether these basic daily needs had been met. However, the CCTV recordings reviewed by Inspectors confirmed that where a prisoner had requested a shower, or to use the telephone or to access the exercise yard, this was facilitated. It was unclear to Inspectors from the records reviewed whether further requests for showers made during the day were granted.

3.55 Prisoners told Inspectors that they were not offered a shower at weekends at Maghaberry. At the last full inspection of Maghaberry in 2018, prisoners who had spent one or more nights in the CSU in the last six months were asked if they could shower every day. A total of 62% (24 of 39) answered 'No'. In response to the same question, 46% (79 of 170) of the general population in Maghaberry responded 'No', while at Magilligan in 2017 this was just 4% (5 of 119). When Inspectors reviewed a selection of request sheets, there were no requests recorded for showers at weekends. Inspectors also noted that one of the weekend shifts was currently short of staff, which was causing difficulty in maintaining the regime. Accounts given by prisoners and stakeholders along with request sheets reviewed by Inspectors, provided no assurance that prisoners were getting out of their cells over weekends for the purpose of showering. Inspectors raised these concerns with senior Governors at the prison and were told this would be resolved immediately.

3.56 Although requests were made in the morning, Inspectors saw evidence that prisoners could use the telephone on multiple occasions during the day at Maghaberry and Hydebank. The only limitation to the duration of these calls was managing the number of prisoners who requested to use the telephone. From the CCTV recordings, there was evidence of prisoners at Hydebank being asked to shorten or end calls to facilitate another prisoner to use the telephone, as there was only one telephone in the CSU. For those on Rule 32 at Magilligan, there was again unlimited access to the telephone, but those on cellular confinement, were only permitted one call each day and that was limited to 10 minutes. Inspectors found this to be unduly restrictive and not in keeping with practice at other prisons.

3.57 Relatively few prisoners made use of outdoor exercise yards. For example, at Maghaberry the review of CCTV recordings for a five-day period Monday – Friday showed that the two exercise yards were used by 13% (9 of 70) of the prisoners in the CSU at that time. Prisoners told Inspectors there were many reasons that they didn't use the yards including: sufficient staff to facilitate request; poor weather and the poor environment. One prisoner also told Inspectors, "*If you don't request anything in the morning you don't get anything for the rest of the day*".

3.58 Prisoners reported that they did not get to use the internal gym at Maghaberry although one prisoner said that he had used it. Another prisoner told Inspectors, "*I asked to go to the gym every other day but told I had to do 21 days. [I was] told yesterday after you [*Inspectors*] arrived that I could go to the gym*." The gym in Maghaberry CSU and the indoor exercise equipment at Magilligan and Hydebank were not observed being used on the CCTV recordings. Inspectors observed one man being taken out of the CSU for a short walk by staff and were told of other occasions when use of the internal gym had been encouraged and of staff spending time in the yards with a prisoner to encourage him to avail of activity outside.

3.59 Generally, prisoners had a radio in their cells but the policies setting out access to televisions were different at each CSU. For all prisoners at Hydebank and those on Rule 32 at Magilligan, the general rule was that all prisoners were given a television. For those on cellular confinement at Magilligan and all prisoners held at Maghaberry, the policies were that televisions were provided based on prisoners demonstrating a period of good behaviour regardless of the reason they had been segregated. There were occasions when it was appropriate to withhold televisions. Inspectors saw evidence where they had been removed to prevent a risk of harm or had been repeatedly damaged. There was clear evidence from prisoners that televisions were the main way that many of them offset the impact of isolation. Inspectors do not understand the rationale behind the current inconsistent approach to the provision of televisions. Inspectors do not support the routine removal of televisions without an assessment of risk and impact on prisoner wellbeing that is documented and regularly reviewed.

3.60 The operating procedures/Governor's Orders for each CSU indicated that prisoners were risk assessed to determine if they could associate with each other in the CSU but we found no evidence of peer association actually happening. This was confirmed by prisoners and a senior manager. Should practice change and association permitted in appropriate circumstances, there were no internal facilities for this to take place at Maghaberry and Magilligan (see paragraph 3.11). Inspectors identified an immediate need at each CSU to implement effective procedures that proactively encouraged association between prisoners and a need to provide suitable facilities for this to happen.

Purposeful activity

3.61 Two Further Education colleges worked in collaboration with the NIPS to deliver learning and skills provision across the prisons. The North West Regional College (NWRC) worked in partnership with Magilligan while Belfast Met worked in partnership with Maghaberry, Hydebank Wood and Ash House. From April 2021, a new Service Level Agreement was introduced and Belfast Met was appointed to manage further education provision across all prisons.

3.62 The evidence showed that contact by learning and skills staff with CSU-based prisoners was infrequent. For men and women segregated in the CSU, there was no formal, consistent or systematic approach used in any of the prisons to inform the learning and skills staff that prisoners had been transferred there from the general prison population. A small number of tutors had visited prisoners who were enrolled in their classes in order to deliver workbooks, practice exams, or to provide certificates of achievement to those due for discharge. Learning and skills staff were not consulted sufficiently about prisoners in the CSU, including what classes they were already enrolled in or how they could be supported to continue their learning. Prisoners said that they had wanted to continue with learning and skills or would have welcomed opportunities for further stimulation to break the long periods in isolation and maintain their general well-being. Apart from Hydebank, there were limited spaces and facilities to enable teaching or any learning in CSUs.

3.63 Since the COVID-19 pandemic lockdown in March 2020, there had been no learning and skills provision nor contact with any tutors for prisoners segregated in the CSU. A limited number of online classes across a range of curriculum areas were introduced from June 2020 for those prisoners in the general population, but this did not include those held in CSUs. At the time of the review, the technical infrastructure was not available in CSUs to support virtual learning.

OPERATIONAL RECOMMENDATION 6

The Northern Ireland Prison Service in partnership with Belfast Metropolitan College and North West Regional College service providers, should immediately ensure that learning and skills providers are notified when men and women are transferred to the Care and Supervision Units.

3.64 There was disconnect in the recording system between the prisoners' educational Individual Learning Plan (ILP) and their Personal Development Plan (PDP). It should be a priority to ensure that the information on both documents is better aligned, more easily shared, accessible and acted upon in a coherent, consistent and meaningful manner to maximise the opportunity for all prisoners, including those in the CSU, to progress in a timely way in their learning.

OPERATIONAL RECOMMENDATION **7**

The Northern Ireland Prison Service in partnership with Belfast Metropolitan College and North West Regional College service providers, should develop a common and effective recording system for all prisons to share information on Individual Learning Plans and Personal Development Plans to enable all prisoners, including those in the Care and Supervision Units, to continue and progress their learning. This should be completed within six months of the publication of this report.

3.65 At Maghaberry, a limited range of resources were available, such as activity packs, games, jigsaws and books. A few prisoners reported that during their stay in a CSU the library books were limited and often in poor condition. Contact between the Physical Education (PE) instructors and the men in the CSU was limited with no time allocated specifically for those in the CSU to use any of the PE facilities. This is a missed opportunity to encourage prisoners to avail of exercise programs to support their physical and mental health and well-being.

3.66 Prisoners in Magilligan CSU had access to a limited range of resources, such as distraction/activity packs, DVDs and library books. Prior to the pandemic, the gym (outside the CSU) had been made available one morning per week. This was subject to permission and a desire to use it. Inspectors found very few prisoners actually used the facility.

3.67 Before the pandemic, prisoners at Hydebank Wood and Ash House who were deemed eligible to leave the CSU had been offered one-to-one sessions in the gym with the PE instructors up to three times a week. Two pieces of gym equipment were also available in the CSU recreation room but Inspectors did not observe them being used.

3.68 In Hydebank an excellent library service was provided to both prisons. The librarian had scheduled visits and was observed visiting the CSU during the inspection fieldwork. This occurred at least once weekly with a mobile unit; the librarian provided a very good range of quality library books and engaged in supportive and/or creative activities with the young men and women, such as the Shannon Trust '*Turning Pages*' and '*Book Folding*'.[20] In the most recent surveys[21] conducted at Hydebank Wood and Ash House in 2019, 91% (70 of 77) of the women and young men who used the library indicated that the library had a wide enough range of materials to meet their needs and 27% (30 of 112) indicated that they went to the library twice a week or more.

20 *Shannon Trust Website, Turning Pages* available at **https://turningpages.shannontrust.org.uk/**
21 HMIP surveys are based on stratified random samples of the prison population and the results and methodology are appendices to each inspection report.

Photograph 14

Photograph 15

Library facilities at Hydebank Wood

Record keeping

3.69 Written journals and the request sheets used at Maghaberry were a core part of daily governance arrangements used in CSUs but they provided limited insight in providing evidence of engagement, time out of cells and access to purposeful activity.

3.70 Inspectors found no consistency in how journals were completed, either between shifts at individual prisons or across all three prisons. Some journals recorded external prisoner movements and incidents and others recorded detailed information about time out of cell for showers, exercise and telephone calls.

3.71 The information recorded on daily request sheets or journals was not being collated to produce more meaningful longitudinal information about individuals during segregation in a CSU and there was limited evidence of supervisory checks. Over and above the journals, there was no other mechanism for recording time out of cell and purposeful activity so that this information could be available for audit and to provide assurance about the provision of basic entitlements.

3.72 Technical solutions in other areas of the Northern Ireland criminal justice system were already providing robust governance arrangements for prisoners. An example of this was the PSNI Niche IT system, which had replaced paper based custody records with bespoke custody functionality. During a recent CJI inspection of police custody[22], it was noted that the system enabled staff to accurately record prisoner movements, visits, exercise, meals, showers and access to telephone calls. This real-time system merged all inputs to provide centralised details on all aspects of the prisoner's detention. Supervisors and staff routinely checked the system to ensure necessary actions were timely and in the best interests of the detainee. Police custody suites and CSUs share many common challenges around prisoner detention. The bespoke IT solution used by the PSNI provided evidence that technology was already delivering effective governance solutions to safeguard prisoners. The CSU is a unique environment and Inspectors are not satisfied that existing technology and paper based records are meeting those needs.

22 *CJI Police Custody, The Detention of Persons in Police Custody in Northern Ireland, September 2020,* available at **http://www.cjini.org/TheInspections/Inspection-Reports/2020/July-September/Police-Custody**

OPERATIONAL RECOMMENDATION 8

The Northern Ireland Prison Service should immediately start to develop and implement an effective technical solution to record access to basic needs, time out of cell and purposeful activity targets throughout a prisoner's time in a Care and Supervision Unit to provide a complete and instant overview for staff and others, effective audit and external scrutiny.

Care and support

3.73 Governor's Orders and Standard Operating Procedures required Duty Governors and health care to visit all those held in a CSU on a daily basis. Although visits by Duty Governors were not routinely recorded in landing journals,[23] evidence examined or obtained (including CCTV and body worn camera recordings), confirmed that these visits took place. Duty Governors spoke to prisoners at their cell doors and were accompanied by CSU officers. Most visits were brief and were largely limited to asking if individuals had any requests or complaints. Several prisoners said that if they had wanted to speak to the Governor about something personal at the cell door it would have been awkward, as everyone could have heard them, including other prisoners.

3.74 Records Inspectors examined did not demonstrate that Duty Governors routinely checked landing journals or requests sheets (see paragraph 3.54) to inform their visits with prisoners and that they relied on officers to confirm what requests had been made by prisoners. Duty Governors completed a daily report proforma. The report informed the Governor in charge and local Senior Management Team about relevant events over a 24-hour period (0800-0800 hours) and provided handover information to the oncoming Duty Governor and day managers. CSU entries routinely reflected 'no issues' while comments referring to prisoners on Rule 32 often stated that, *'all on Rule 32 spoken to.'* Given the significance of such visits, records did not provide any meaningful information on key aspects, such as wellbeing and provision of basic entitlements.

3.75 Inspectors examined care records contained on EMIS. The case notes provided clear evidence of daily visits by Primary Health Care staff and contained input from a multi-disciplinary team comprising, physiotherapy, occupational therapy, GP and dentist. This provided assurance that any health care needs already in existence prior to arrival at the CSU were known to Primary Health Care who reviewed them, so that treatment continued for patients while in a CSU. Inspectors found no impediments to patients care needs as the result of being relocated to the CSU. The notes contained assessments of the patients' physical appearance and engagement with the Primary Health Care nurse along with indicators of their mental and emotional well-being. Improvement is required to ensure consistency of approach for the completion of records and care planning. Inspectors identified this concern during fieldwork to the leads for Primary Health Care and Mental Health Care. Most prisoners Inspectors spoke to reported that they could speak openly to nurses and that the care they received was good.

23 The CJI audit of landing journals showed that on average, only 27% of the journals contained an entry to indicate that the Duty Governor had visited or had signed the journal. Duty Governors who visited the CSUs each day had only sporadically signed the journal.

OPERATIONAL RECOMMENDATION 9

The South Eastern Health and Social Care Trust should ensure that mental health care documentation records the assessed need of the patient and meets professional standards within three months of the publication of this report.

3.76 Visitor logs showed that support from staff in AD:EPT, the Mental Health Team (MHT) and PSST continued during the COVID-19 pandemic but visits by others including chaplains and the IMB had ceased for a period. IMB weekly visits to CSUs had resumed at Maghaberry but not at Magilligan and Hydebank.

Individual needs, exit and reintegration planning

3.77 The Rule 32 documentation reviewed by Inspectors that authorised detention did not consider individual risks and needs of how the prisoner was likely to respond to segregation in the CSU. Rule 32 case conferences to review detention were not informed by a risk assessment or problem formulation. Rule 32 case conferences and oversight meetings did consider specified regimes, discipline reports and recommended engagement and additional support systems but these were not integrated with nursing plans, PDPs or ILPs. During a later visit to Magilligan in 2021, Inspectors noted that the MHT and the CSU team and managers had worked collaboratively to develop a safety plan for an individual while in the CSU. The plan provided advice for CSU staff on how to respond to specific behaviour and triggers and an individually tailored activity schedule.

3.78 The Review examined what steps had been put in place to plan for an individual's exit from the CSU at the earliest opportunity. Exit plans were incorporated within the Rule 32 proforma[24] but in the paperwork reviewed in the case reviews, plans were seldom considered until later in detention and when plans existed, they often contained general statements rather than specific targets. Exit planning was also considered at prison oversight meetings and these measures were documented on separate proformas. Exit planning was also considered by HQ Governors staff considering extension requests (see paragraph 2.6). In individual cases, the documentation meant it was difficult to follow the progress against the steps identified. A HQ official told Inspectors that he sometimes struggled to piece together the history of the case when conducting Rule 32 applications for further detention. There was limited evidence in the paperwork provided that reintegration plans were routinely developed for those leaving CSUs.

3.79 In one case examined by Inspectors, a management plan was provided for a prisoner returning to normal accommodation at Maghaberry. It had been prepared after the Rule 32 review process had been completed. Inspectors were told that the plan had been developed because of specific risks and concerns posed by the individual on return to normal location. It was not clear to Inspectors what specific criteria was being used to decide when a management plan was required and this was resulting in practice that was inconsistent.

24 *Rule 32 Case conference template: 'Details of any agreed plans/activities as a pathway off Rule 32 (exit plan)'.*

3.80 Those 'awarded' cellular confinement returned to normal location at the end of the period they had been 'awarded' at adjudication. Prisoners could be returned earlier on the authority of a Governor. There was evidence that cellular confinement was suspended due to individual circumstances and concerns of a prisoner's well-being. Under Rule 35(4), prisoners could be held in a CSU for up to 48 hours. At the end of this period, the prisoner returned to normal location or if further segregation was deemed necessary and proportionate, a period of Rule 32 could be authorised.

Health Care services

3.81 The SEHSCT provide health and social care services in all prisons in Northern Ireland. The NIPS estate has no health care in-patient facility. Primary Health Care and Mental Health Care Teams in all prisons delivered on-site service provision. Health care recruitment had been undertaken across the three sites, which had strengthened the leadership across both teams. Inspectors anticipate this will lead to improved outcomes for prisoners in the future.

Primary Health Care provision

3.82 Primary Health Care staff provided a 24-hour, seven day a week service across all prisons including to those held in CSUs. There was good collaborative working relationships with NIPS staff at all levels across all three sites. The relationship was respectful and health care staff felt supported and confident to challenge decision making about the health of all prisoners held in CSUs. Prisoners were very positive about their relationship with health staff and said they were assisted whenever they required support.

3.83 All new arrivals into the CSU received an initial health screen by nurses within two to four hours of their segregation. However and as previously highlighted, there was no direct involvement by health care when an 'award' of cellular confinement was made as part of the adjudication process (see also paragraphs 2.10-2.14). The initial health screen included an assessment of any injuries, medication review and was to determine mental health or learning disability concerns. When Primary Health Care identified needs in relation to a prisoner's mental health, a referral was made to the MHT for assessment. Inspectors were satisfied that referrals were mostly appropriate in line with the referral criteria as set out in Trust policy. Inspectors were advised that an initial assessment and referral criteria to the MHT was currently being developed. The SEHSCT planned to increase the initial health screen from two to four hours (see paragraph 3.33).

3.84 Primary Health Care staff attended the CSU daily to assess prisoners and administer medication when required. When possible, medication was administered in a treatment room that offered the opportunity for prisoners to leave their cells. Prisoners in CSUs could access health care staff that included physiotherapy, occupational therapy, GP and dentist. However, some prisoners told Inspectors about lengthy waiting times to see a GP, although this was comparable to waiting times in the community. There was also good feedback about relationships and engagement with Primary Health Care and Mental Health Care nurses.

Mental Health Care service provision

3.85 Mental Health Care services were available seven days a week from 9am to 5pm at Maghaberry, the other sites only provided a five day service. Inspectors heard about intentions to extend seven-day service provision to all prisons, however, there was no clear planned timeline to progress such a change.

3.86 The Primary Health Care team managed the provision of mental health services outside the core working hours. The options available to Primary Health Care were to make use of SPAR Evolution procedures (see Definition) or, to consider transfer of a prisoner to the local Emergency Department to maintain safety and minimise risk.

3.87 The Primary Health Care team did not feel adequately trained or skilled to manage a prisoner in a mental health crisis. The current service for Mental Health Care provided outside core working hours was a cause for concern to Inspectors, most notably when prisoners in the CSU experienced a mental health crisis.

OPERATIONAL RECOMMENDATION 10

The South Eastern Health and Social Care Trust should put in place workforce planning arrangements for accessing out-of-hours mental health crisis response services within three months of the publication of this report.

3.88 MHTs worked collaboratively with community teams when someone was already known to community services regarding the sharing of information. Risk assessments were shared promptly and this was enabling health care staff to have a better knowledge of prisoners' mental health history. However, Health Care did not attend Rule 32 case conferences other than by exception. Some prisoners told Inspectors they lacked and needed this support at conferences during which decisions were made about extending segregation and about their reintegration back to normal population. Inspectors believe that better outcomes for prisoners can be achieved through full engagement of Health Care at all Rule 32 case conferences.

Medicines management

3.89 Only Maghaberry had dedicated pharmacy technician staff for the management and preparation of medicines. The administration of medication to prisoners in the CSU continued to be provided by Primary Health Care nurses. Medicines management was in line with professional standards. Medicines within the CSU were routinely given under supervision by Primary Health Care staff. All others received medication from the clinical room hatch. Medicines were kept in locked cupboards and the medicine trolley within the Health Care clinical room. All were safe and secure and within their expiry date.

Infection prevention and control practices for COVID-19

3.90 When visiting CSUs, Inspectors observed that SEHSCT staff and NIPS staff were complying with national and regional best practice guidance in maintaining a COVID-19 safe environment; this included the key practices of hand hygiene, use of personal protective equipment and social distancing measures. Staff knowledge in relation to transmission-based precautions was good and all staff questioned were very clear on what actions to undertake if they or patients developed symptoms suspicious of the COVID-19 virus.

Quality improvement

3.91 Inspectors were told of a positive learning culture and ethos of quality improvement among health care staff providing services at Hydebank Wood and Ash House. The leadership of health care within the prison was apparent from the vision held by team leads and had delivered improvements within the service.

STAFF SELECTION, TRAINING AND SUPPORT

Staff levels

3.92 At the time of fieldwork, 41 staff were permanently appointed to work in the CSU across the three sites. Table 1 provides an overview of staff allocation.

Table 1: Staff allocated to CSUs across three prison sites

	Total appointed			Daily deployment		
	Maghaberry	Magilligan	Hydebank	Maghaberry	Magilligan	Hydebank
Senior Officer	2	2	1	1	1	1*
Prison Officers	18	10	8**	8	4	3

* Responsible for CSU but not based in the unit. ** Other additional staff are used when required.

Staff selection

3.93 There was no policy for the selection of CSU staff. Officers were identified by Governors or Senior Officers and appointed by the Governor in charge and Deputy Governor. Evidence showed that some staff had been redeployed when later found unsuitable for the role while senior management told Inspectors that they did not want to advertise positions due to a lack of confidence in competency-based interviews to identify staff that were suitable, *"... in terms of their commitment, etc.."* A Hydebank Governor's Order attempted to identify the 'special' skills and qualities of staff selected to work in the CSU and of the level of engagement with prisoners expected. Only Magilligan had a job description for CSU staff but it did not adequately describe the role, skills and expectations of staff working in CSUs. Instead, it focused purely on operational responsibilities and it had not been specifically designed for the selection of staff.

3.94 The current absence of a fully developed job description was not conducive to practice that promoted understanding and openness. Inspectors received many complimentary reports about CSU staff but there was strong criticism about perceived inadequacies in the current practices used to recruit permanent CSU staff. Inspectors did not consider current selection practice sufficiently open, fair or transparent to all eligible staff.

Staff training

3.95 The experiences reported by prisoners were mixed. Prisoners at Magilligan and Hydebank Wood mostly reported positive relationships with staff while most negative comments were reported about the staff at Maghaberry. Examples of good individual treatment, support and care were mainly attributable to individual members of staff who had shown compassion in particular circumstances. Sometimes it had been little more than a five-minute chat or help with an item of clothing. One prisoner told Inspectors, *"The staff are brilliant. They are helpful"*. Not all accounts were complimentary. One prisoner said that, *"one time I asked for water and they said to drink out of the tap"*. Another claimed that, *"staff seemed to goad the prisoners"* and another said, *"They throw in comments about your mental health [like] you're mad in the head"*.

3.96 There was no formalised training and development programme for new and appointed staff and no training needs analysis of the skills and competences for the role. Induction was limited to shadowing staff that were more experienced. Inspectors consider the current approach to be inadequate given the nature of the role.

3.97 We were told that only experienced staff were selected to work in CSUs. Several senior managers told Inspectors that core training provided to all staff was adequate for the role along with experience and *"jail craft"*. However, this was not the view of all senior managers or the majority of CSU staff, stakeholders and prisoners. There was overwhelming support for staff to be equipped with better training, particularly in areas of induction to the role and prisoner mental health.

3.98 CSU staff consistently raised concerns about their training and development, as they wanted the skills to work more effectively with segregated prisoners. The training identified to Inspectors by staff and managers included training in Adverse Childhood Experiences, motivational interviewing, dementia awareness, de-escalation techniques and mental health awareness.

3.99 Many CSU staff provided examples and told Inspectors that they learned how to manage certain behaviours based on trial and error or in conversation with their peers and/or other professionally trained staff. In one example, an officer told Inspectors that, *"one person had a psychotic episode and he thought his skin was crawling. We spent all day with him. Felt we were winging it but we did our best and did feel that we did a good job."*

3.100 Inspectors were aware that training had been provided but were not assured that all Governors involved in applying Rule 32, Rule 35(4) and adjudications or those responsible for extending Rule 32 periods had received formal training. Operational training provided to new Governors included mentoring/shadowing and instruction by Senior Governors on how to apply Prison Rules and policy. The NIPS Legal Adviser provided awareness on legal issues, which staff reported, was helpful.

3.101 A NIPS *'Future Leaders'* programme[25] delivered training to 10 officers in 2019 that aligned with the role of Unit Manager Governor. The programme identified training needs necessary for the role with a specific module on the conduct of Rule 32s. Inspectors repeatedly heard from those on the programme just how beneficial their training on Rule 32s had been. Inspectors were in no doubt that similar training should be developed and delivered to all new and existing Governors required to deliver such obligations under Rule 32.

Staff well-being and supervision

3.102 Some staff were upset and emotional about the sense of helplessness they had experienced when trying to do their best to support prisoners in CSUs. Others described the long lasting impact resulting from their daily work with some prisoners. Several behavioural logs examined by Inspectors provided evidence that CSU staff were exposed to sustained periods of verbal abuse and repeated threats of violence from prisoners.

3.103 Staff at each CSU described themselves as 'tight-knit' groups who looked out for and supported each other. They generally relied on informal peer-to-peer conversations for help and support when incidents or difficulties in managing certain situations or individuals occurred.

3.104 Staff were aware of the telephone counselling service and spoke about asking for support from line managers if needed. The CSU officers also said that they welcomed any regular professional clinical supervision that could be provided to them, but pointed out that this was not currently available to CSU staff.

3.105 There was an over reliance by staff on peer support when critical incidents occurred. This was consistent across almost every conversation and interview with CSU staff. While some knew of the guidance for 'hot and cold' debriefs following a critical incident, there no evidence of their use in the CSU. One officer said, *"the only debrief they ever had was when there was a bigger incident in the prison."* The NIPS need to actively promote and encourage CSU staff to seek help and support outside their own group/team and to ensure that debriefs for incidents were taking place.

25 The CJI Inspection Programme for 2021-22 includes an inspection of leadership development and wellbeing across the criminal justice system. Terms of Reference are available at **https://www.cjini.org/NewsAndEvents/Latest-News/Terms-of-reference-for-Leadership-Development-and**

3.106 The Minister of Justice had commissioned a review of support services for operational prison staff that was completed in November 2020.[26] The review report set out a number of strategic recommendations and dealt specifically with training provision for all staff. It was encouraging that research conducted for the report recognised the benefits of whole system approaches such as Trauma Informed Practice and the many benefits it could provide to staff working in the NIPS.[27] Inspectors support and echo the specific contents of Recommendation 3 as it relates to training, mental health awareness and resilience; Recommendation 4 as it relates to organisational climate; and Recommendation 7 as it relates to supervision.

26 *DoJ, Review of support services for operational prison staff, November 2020* available at **https://www.justice-ni.gov.uk/sites/default/files/publications/justice/nips-report-jan-21.pdf**

27 *Academy for Social Justice, Understanding and Use of Trauma Informed Practice, October 2018,* available at **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/746766/Trauma_informed_practice_seminar_SW_8_Oct_2018_slides.pdf**

CHAPTER 4: OUTCOMES

4.1 Chapter 4 examines outcomes for prisoners who were segregated and addresses objectives two and three of this Review. Outcomes were assessed against separate HMIP *Expectations* on segregation for men and women.

4.2 The CSU facility at Hydebank for young men had changed to a joint facility for young men and women in October 2020. Prior to 2020, women were not placed in a separate CSU, but instead remained in their own cells, were relocated elsewhere in Ash House, or were segregated in a dedicated area within Ash House.

4.3 Given the new CSU arrangements for women, the main body of reporting on CSUs relates to outcomes for male prisoners. Nonetheless, Inspectors have made recommendations based on early observations about outcomes for women, which are reflected in this Chapter.

Care and supervision or punishment

4.4 The supervision aspect of the operation of CSUs was much in evidence at each site and all staff wore uniforms except at Hydebank. Some prisoners were in the CSU because suitable caring accommodation had not been identified elsewhere and included those who were mentally unwell, had physical health needs and others with complex underlying behaviours and difficulties. Different staff groups referred to CSUs as being *"low stimuli"* environments that could support an individual's care. Prisoners talked about their loneliness, their despair and the boredom of having nothing to do all day but lie in their cell with little to do.

4.5 Prisoners told Inspectors they sought sanctuary in the CSU to get away from drugs and substance abuse and to escape bullying and intimidation. They said they used the CSU to "*dry out*" and "*detox*". Others described it as a place where they had "*time out*" had "*time to reboot*" and time to "*get my* [their] *head straight*".

4.6 The 2013 policy and guidance document on the application of Rule 32 for Governors and DoJ Representatives stated that Rule 32 must not be viewed as a punishment. The policy also stipulated that a prisoner should not suffer any detriment to regime or privileges while accommodated under Rule 32.

4.7 Staff consistently told Inspectors that prisoners were not sent to the CSU to be punished and that, "*the deprivation of liberty* [being removed from their normal location] *is the punishment*". CJI first inspected Maghaberry Prison in 2005.[28] The name of the Punishment Unit had changed to the Special Supervision Unit (SSU) but Inspectors reported that, '*The segregation unit was still known locally as the punishment unit, and practices there were outdated*'. During CSU fieldwork in 2021, the prisoners at all sites still referred to the CSU as, "*the block*" and described it as a place of punishment and "*like a prison within a prison*." Residential staff had mixed views of the role of the CSU with some describing it as a deterrent and place of punishment and others as a place to reset, where prisoners could receive more personal attention from staff.

4.8 While a range of awards were awarded[29], the adjudication procedure also 'awarded' punishments that resulted in prisoners being sent to the CSU with an outcome resulting in segregation in cellular confinement. It is the view of Inspectors that NIPS policy and practice determined the CSU to be a place of punishment. It was also evident, and as outlined in this report, that use of the CSU was not limited to just punishment but extended far beyond this (people held under Rule 32 and Rule 35(4)); some of which was determined by the NIPS and on occasions, use that was manipulated by the prisoners themselves.

4.9 Current use of the CSU had resulted in providing accommodation for prisoners with a complex range of needs. Many prisoners found themselves in the CSU for non-punitive reasons. Inspectors expect the regime of such individuals to mirror (so far as possible) the regime and privileges of those in normal residential accommodation. This was not the case and all prisoners in the CSU were subject to similar and restricted regimes regardless of why they were held there.

4.10 The NIPS viewed loss of liberty to be the punishment and that cellular confinement must only to be considered as a last resort. While not normal practice, Inspectors found some examples where cellular confinement was 'awarded' in conjunction with other adjudication punishments, such as loss of privileges, loss of association and exclusion from associated work. This outcome significantly affected the conditions of prisoners segregated in the CSU on an 'award' of cellular confinement. Inspectors viewed such combination of 'awards' in conjunction with an 'award' of cellular confinement to be excessive. It is not in the best interests of any prisoner as doing so has significant ramifications in an already very restricted regime.

28 *CJI, Report of an unannounced Inspection of Maghaberry prison, October 2006*, available at *http://www.cjini.org/getattachment/eb9b39c5-3ee2-4c66-a5f9-00c503fac261/Maghaberry-Prison-May-2006.aspx*

29 See Chapter 1, para 1.9.

CASE REVIEW 1: PRISONER F, 35 YEARS, MALE

The prisoner was 'awarded' five days cellular confinement. This was their first time in the CSU and he did not spend any further period there during his sentence. He had a history of anxiety, depression and medication misuse. The offence was that a mobile telephone and cable had been found hidden in his cell. The prisoner had already spent 48 hours in CSU on Rule 35(4) after being charged with the offence. In addition to an 'award' of cellular confinement, he was also 'awarded' 14 days loss of gym and sports and loss of evening association.

4.11 The Progressive Regimes and Earned Privileges scheme (PREPs) operated across all three sites and was being applied to those segregated in the CSU (the scheme had only recently been introduced at Maghaberry). Those in the CSU did not benefit from additional privileges that came with enhanced status. Inspectors noted a case where a prisoner already in the CSU on Rule 32 was punished through demotion in regime under PREPs.

Living conditions

4.12 Prisoners were very likely to experience segregation very differently at each establishment. Segregation is used for punishment as well as non-punitive reasons. Like the design of all prisoner accommodation, the CSU needs to satisfy both operational and delivery requirements. Meeting those requirements does not mean that quality should be compromised and this is particularly important given the very vulnerable and mentally ill prisoners being segregated there.

4.13 New normal residential accommodation (Davis House) had officially opened[30] at Maghaberry in 2019. The design of Davis House sought to improve the well-being of staff and outcomes for prisoners and included: the use of colour and different materials to create a sense of individual space; the creation of open, bright areas and small and large communal areas; choices of external recreational and horticultural areas to increase self-efficacy and reduce anxiety; and cells had showering facilities and access to personal in-cell computers.

4.14 Similar features were reflected in the design and development of the CSU at Hydebank in 2019. While a focus remained on maintaining a safe and secure environment, the design also sought to enhance the mental well-being of prisoners. All staff and service providers that Inspectors met were very positive about the design of the CSU, especially those who had previously worked in the old CSU (for young men only) at Hydebank Wood. Prisoners were complimentary about the quality of the accommodation (and staff). One prisoner told Inspectors, *"The new CSU is very relaxing and with the colours and all [.....]. Anyone who was in the old CSU would get a shock if they saw the new CSU."*

30 DoJ, *New £54m prison block marks innovative next chapter for Maghaberry, October 2019*, available at: *New £54m prison block marks innovative next chapter for Maghaberry | Department of Justice (justice-ni.gov.uk)*

4.15 The experience of those suspected of concealing unauthorised or prohibited items also varied significantly between establishments. 'Recovery Cells' were used to aid the retrieval of any unauthorised or prohibited articles concealed internally by a prisoner (see Appendix 5). At Magilligan and Hydebank, these cells almost mirrored normal cells but instead of a permanent toilet were equipped with a portable chemical toilet. Maghaberry used two 'Dry Cells' (see Appendix 5) to aid the retrieval of any unauthorised or prohibited articles concealed internally by prisoners. These were 'bare unfurnished cells without normal furniture, fittings, bedding or clothing'. Inspectors examined both and found them to be particularly spartan. At Magilligan and Hydebank, new cell furniture was either being tested or due to be tested but there were no plans to do the same at Maghaberry.

4.16 No project evaluation/review had been conducted of either Davis House or the CSU at Hydebank to establish the range of improved outcomes for prisoners or how this learning could help inform the development of other parts of the prison estate, and in particular, the CSUs at Maghaberry and Magilligan. Inspectors found that the physical environment and facilities available at the CSU at Hydebank were the best of the three CSUs within the NIPS estate. A strategic approach is needed to modernise all CSUs to improve outcomes for prisoners.

Provision for women

4.17 In 2011, 'The review of the Northern Ireland Prison Service' (referred to as the PRT report),[31] found that, *'the current custodial environment for women, in Ash House, is wholly unsuitable: because of its design, its mixed population of short-sentenced, remanded, mentally ill and long-sentenced women, and its co-location with young adults'*. The report was commissioned following the Hillsborough Agreement to review the, *'conditions of detention, management and oversight of all prisons... [and] consideration of a women's prison which is fit for purpose and meets international obligations and best practice'*.[32]

4.18 Staff told Inspectors that segregating women in Ash House negatively affected the normal functioning of the house for many in the general population. Prisoners said that the quality of the accommodation and regime available to segregated prisoners was poor. Senior Governors acknowledged this, and told Inspectors that limited work could be done as a business case for a new dedicated women's prison was being progressed. Inspectors are of the view that the current women's prison is not designed or built to accommodate a CSU and that the accommodation is unsuitable for such a purpose in its present state.

31 *Prison Review Team, Review of the Northern Ireland Prison Service, Conditions, management and oversight of all prisons October 2011,* available at **https://cain.ulster.ac.uk/issues/prison/docs/2011-10-24_Owers.pdf**

32 *The Agreement at Hillsborough Castle, February 2010*, available at **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/136435/agreement_at_hillsborough_castle_5_february_2010.pdf**

4.19 The Mandela Rules (Rule 11a) clearly sets out that, '*Men and women shall so far as possible be detained in separate institutions; in an institution* which receives *both men and women, the whole of the premises allocated to women shall be entirely separate*'.[33] HMIP *Expectations* for women are underpinned by an ethos that women, '*...should no longer be held in custody which was designed for men and merely adapted slightly to accommodate women*'.[34] The recent change in the CSU at Hydebank from young men only to one now shared with women prisoners was a serious concern to Inspectors.

4.20 During this review two mentally unwell women had been held in the CSU pending transfer on a Transfer Direction Order since its opening. Inspectors were told that this was a very disruptive period for other prisoners resident in the CSU. Inspectors witnessed the impact that one distressed female on a SPAR Evo had on the whole environment and the efforts of staff to maintain privacy and dignity for the individual concerned.

4.21 Staff were vigilant and responsive to prisoners during visits to the CSU but Inspectors were not satisfied with current arrangements for privacy nor were they assured that women were adequately protected from the risk of abuse from young men. Some of the cells occupied by the young men overlooked the exercise yard and this impacted on privacy for women using the yard. Inspectors raised these concerns with the Governor in charge and the Deputy Governor immediately following inspection of the shared CSU in February 2021.

OPERATIONAL RECOMMENDATION 11

The Northern Ireland Prison Service should review the shared Care and Supervision Unit at Hydebank in line with Rule 11(a) of the Mandela Rules so that men and women are held separately and their individual needs met. This should be done within six months of the publication of this report.

Prisoners are only segregated with proper authority and for the shortest period

4.22 From 1 January 2019 to 30 November 2020, 41% (326 of 796) of Rule 32s at Maghaberry lasted for up to three days. At Magilligan, this figure was 58% (147 of 252) while at Hydebank it was 41% (92 of 226). Since opening on 5 October 2020 to 30 November 2020, two of six women held in the new CSU were segregated for up to three days. Some prisoners spent very long periods on Rule 32. From 1 January 2019 and to 30 November 2020, 33% (261 of 796) of segregation on Rule 32s was for 15 days or more at Maghaberry. At Magilligan it was 18% (44 of 252) and at Hydebank 24% (54 of 226). One woman had been held in the CSU for more than 42 days. Some individuals were segregated for significant proportions of their overall time in custody.

33 *Mandela Rules, United Nations Office on Drugs and Crime, The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)*, December 2015, available at **https://www.unodc.org/documents/justice-and-prison-reform/GA-RESOLUTION/E_ebook.pdf.**

34 *HMIP Women's Expectations,* available at **https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2021/08/Womens-Expectations-FINAL-July-2021-1.pdf**

4.23 Segregation on Rule 32 was permitted for up to an initial 72 hours or up to 28 days for extended periods agreed by NIPS HQ. Data[35] provided by the NIPS for 2019 indicated that the majority of Rule 32s at each establishment ended before the periods of detention had run to the end of authorised maximum limits. However, the data did not show how many previous extension requests there had been to HQ. This data was helpful in monitoring trends on the use of segregation and the extensions agreed by NIPS HQ. Inspectors noted that it was not routinely captured and used for monitoring by NIPS HQ or by the prisons themselves.

4.24 The figures were lower in 2020. Just over 50% of Rule 32s ended before reaching the maximum authorised limits at Maghaberry (173 of 339) and Magilligan (39 of 76) and 64% (66 of 103) at Hydebank. Those that ended before reaching the authorised limits, generally, ended between one and three days early. Data on the reasons why Rule 32s ended early or the full extension periods requested had not been granted was not centrally recorded. The NIPS need to better understand the reasons why Rule 32s ended early or the full extension periods were not granted and to use this learning to influence better outcomes for other segregated prisoners.

4.25 Between 1 January 2015 and 30 November 2020, NIPS HQ extended the period of segregation in almost 3,000 cases (approximately 507 each year), 69% (2,076 of 2,998) had been for prisoners in Maghaberry. Comparative data was not available to determine if the extensions given had agreed with the periods sought by the prison, had lengthened the period further or had reduced the period. In one case examined by Inspectors, a record stated that the prison's Senior Management Team had directed that the Rule 32 period should be extended. This direction had been made in advance of the case conference held to review further segregation by the HQs Governor. Effective monitoring arrangements are needed to provide assurances and maintain confidence in the role played by the NIPS HQ to oversee extensions.

4.26 A robust approach taken to disrupt the supply of drugs entering prisons had resulted in more prisoners being segregated in the CSUs to ensure their safety and that of others. During the most recent inspections of Ash House and Hydebank Wood in 2019 (published in 2020), Inspectors recommended that an effective strategy should be implemented to reduce the supply of drugs at the joint site. An Instruction to Governors in February 2019[36] applied to prisoners who returned from any form of temporary release. It specified that prisoners should remain in the CSU pending a negative indication from a passive drug dog and advised Governors to request extensions to Rule 32 periods. Inspectors found that there was no record of audit attached to the instruction to indicate that regular review was undertaken to ensure it remains appropriate and proportionate.

35 In 2019, 64% (291 of 457) of Rule 32s ended early at Maghaberry Prison compared with 59% (104 of 176) at Magilligan Prison and 75% (92 of 123) at Hydebank Wood Secure College. For the same period of those which ended early 57% (166 of 291) at Maghaberry ended between one and three days early compared with 73% (76 of 104) at Magilligan Prison and 65% (60 of 92) at Hydebank Wood Secure College.

36 *NIPS, Instruction to Governors 01/19, Passive Drug Dog (PDD) Deployment, February 2019. Not published.*

4.27 The following case review illustrates an example were a prisoner was initially segregated for the purpose of COVID-19 isolation. By the time he went to the CSU, 14 days had already elapsed. Time spent segregated in COVID-19 isolation was in addition to periods spent in the CSU. His detention was subject to the above Instruction to Governors and he stayed in the CSU for 88 days. No drugs were recovered. The policy was not effective in this case and Inspectors considered the 88-day period excessive.

CASE REVIEW 2: PRISONER J, 20 YEARS, MALE

Initially held for 14 days in COVID-19 isolation. Following a passive drug dog and a BOSS chair[37] indication, was segregated in the CSU on Rule 32 for his safety and the safety of others. The PSNI had recovered drugs before his committal. After one day in the CSU drugs were detected on a cigarette lighter that he had initially refused to give to staff. Reports submitted by security supported his continued detention at the initial oversight meeting but he was not drug tested because there were no concerns about his presentation. A weekly oversight meeting recommended the early review of his segregation and a Rule 32 case conference was convened prior to which he failed a further passive drug dog indication. He was relocated from a drug recovery cell to a normal cell in order to progress him out of the CSU. Despite weekly reviews, he remained in the CSU because the passive drug dog continued to indicate drugs on him. He was later transferred out of the CSU to another prison and went into a further period of COVID-19 isolation for 14 days. The total period of segregation in the CSU and COVID-19 isolation was 116 days.

4.28 IMB Annual Reports for Maghaberry had raised concerns that individuals were held for significant periods and that a 'find' was only recovered in 35%[38] of those cases. Examination of search records indicated that drugs and related equipment were regularly recovered in the CSUs although there was also evidence in individual cases where finds were not made.

4.29 Given the very negative impact on prisoner outcomes from the circulation of illicit drugs and psychoactive substances within the general prison population, Inspectors were not surprised to find that at each site, there was a particularly cautious approach to reintegration of those suspected of concealing unauthorised articles.

37 BOSS chair – The Body Orifice Security Scanner is a chair with advanced body scanning technology used for the detection of concealed metal objects.

38 *Maghaberry Prison IMB Annual Report, Independent Monitoring Board's Annual Report for 2018-19,* available at **http://www.imb-ni.org.uk/publications/feb-20/Maghaberry_Annual_Report_18-19.pdf**

4.30 As reported in Chapter 3, the data indicated that the duration of stays for young men at Hydebank Wood had increased in particular. The capacity of the CSU accommodation[39] for young men at Hydebank Wood was significantly higher than that available in the adult male estate. Hydebank had 21 cells per 100 prisoners compared with three per 100 in the other male prisons. The CSU capacity for women was also higher at six spaces per 100 prisoners. Inspectors found no evidence that additional provision was resulting in an increase in use but it is a matter that needs to be effectively monitored.

4.31 The supply and availability of illegal and prescription drugs negatively affected favourable outcomes for prisoners. The CJI 2019 Safety of Prisoners Inspection report recommended that the NIPS consider the introduction of body scanners in Northern Ireland. The use of body scanning technology created significant opportunities to improve safety outcomes resulting from detection and prevention of drugs and concealed articles. Scanners could help ensure that those who were not concealing a prohibited substance would not spend prolonged periods in segregation. The NIPS advised it was waiting on final authority from a Justifying Authority to introduce scanners and they had well progressed plans in place for staff training and implementation. As was currently the case in England and Wales, scanners were not being used for women in Northern Ireland prisons.

4.32 Recent CJI Inspections of Resettlement[40] and Safety of Prisoners[41] had raised concerns about resettlement outcomes for prisoners in Maghaberry and Magilligan who had previously been in custody at Hydebank Wood. These prisoners were easily identifiable to the NIPS by the 'H' prefix to their prison number. Inspectors had identified the need for further analysis. Data provided for this review for the period 2015 - 30 November 2020 indicated that prisoners with 'H' numbers accounted for 53% (707 of 1,322) of those segregated on Rule 32 and Rule 35(4) for Maghaberry and 49% (444 of 905) of those in Magilligan. This matter needs further analysis with regard to segregation in the CSU.

39 Calculated on the basis of the number of cells available in the CSU against the average daily population for 2020.
40 *CJI, An inspection of resettlement in the Northern Ireland Prison Service, May 2018*, available at **http://www.cjini.org/getattachment/1ded7a6c-034e-4a62-bf02-96ee30584645/report.aspx**
41 *CJI, The Safety of Prisoners held by the Northern Ireland Prison Service, November 2019* available at **http://www.cjini.org/getattachment/3a70dd41-7bb3-430d-9901-3ed7a191cf94/report.aspx**

REVIEWS AND CASE CONFERENCES

Prevention of suicide and self-harm

4.33 From 1 January 2015 to 30 November 2020, 8% (300 of 3,737) of male prisoners were being managed under SPAR operating procedures at the time they entered a CSU under Rule 32 or 35(4). During the same period 16% (17 of 107) of female prisoners were on a SPAR when segregated in Ash House. In previous paragraphs, Inspectors identified immediate concerns about the suitability of current segregation arrangements for women in Ash House and at the new joint male/female facility at Hydebank. If that trend continued, 16% of women would be on a SPAR Evo when they went to the new joint facility. Inspectors do not consider this a positive outcome for women.

4.34 During the same period, around 8% (32) of prisoners at Maghaberry were on a SPAR at the time of their adjudication when punished with segregation by way of cellular confinement in the CSU. Maghaberry had twice as many prisoners as Hydebank Wood, Magilligan was 2% and Ash House was 3%. The outcome for these prisoners meant that they had already entered the CSU without assessment by health care professionals about the individual's fitness to participate in adjudication proceedings.

4.35 From 2015, the average duration of time spent in observation cells in CSUs was mostly consistent across each prison at two days. At Maghaberry, a prisoner spent 39 days in an observation cell in the CSU during 2019. In the same year, a prisoner at Magilligan spent 18 days in the CSU observation cell. Inspectors did not agree that prisoners who were on a SPAR Evo should be segregated in a CSU unless the prisoner's physical and mental health had been adequately reviewed by health care professionals prior to an adjudicator segregating a prisoner in a CSU (see paragraphs 2.13 and 2.14).

Those with severe mental illness

4.36 All Governors shared a common and significant challenge at each prison when it came to providing appropriate care and accommodation for prisoners with severe mental health illness and/or severe behavioural issues. Medical markers recorded on PRISM confirmed that segregated prisoners in the CSU suffered from addictions, severe mental illness, behavioural problems, communication difficulties, self-harming and history of self-harming. Inspectors had previously reported that, '*Work is also needed by the wider criminal justice and health care systems to provide alternatives to custody for highly vulnerable prisoners*'.[42]

42 *CJI, Report on an announced visit to Maghaberry Prison 5-7 September 2016 to review progress against the nine inspection recommendations made in 2015, November 2016,* available at **https://www.cjini.org/getattachment/1d77c1e6-8311-413e-ad9d-b9f9aa384506/report.aspx**

4.37 Segregation authorised under Rule 32, included prisoners who were waiting to be transferred for assessment and treatment outside of the prison under Article 53 of the Mental Health (Northern Ireland) Order 1986. Transfer Direction Orders provided the mechanism by which mental health patients were transferred from prison to mental health hospitals in the community.

4.38 From 2017 to 2021, Maghaberry held the majority of patients awaiting transfer under a Transfer Direction Order (49) when compared with Magilligan (four) and Hydebank Wood and Ash House (23). Overall, the average time spent waiting for a transfer from a CSU was 22 days compared with 33 days in other locations in the prisons. Some individuals waited for much longer before they were transferred. The National Health Service Benchmarking Network reported in 2019 that in England, the average waiting time to transfer from prison was significantly higher at 52 days.

4.39 The percentage of patients segregated in a CSU in Northern Ireland prior to their transfer was over twice as high as that in England[43] (16% compared with 7%). Unlike some prisons in England, there are no in-patient beds in Northern Ireland prisons. Staff and prisoners told Inspectors that the behaviour of some patients was disruptive, upsetting, and sometimes created health and hygiene implications for those with whom patients normally lived and associated while in general population. Continued presence on normal residence often resulted in such patients becoming vulnerable due to resentment and bullying from other prisoners. Providing safe, therapeutic and caring environments capable of meeting individual patient needs was paramount.

4.40 A 2017 report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment commenting on its visit to Northern Ireland was emphatically clear in its recommendation that segregation units should not be used as an alternative to normal accommodation for patients with severe mental health conditions.[44] It stated that patients should be treated in, '*a closed hospital environment, suitably equipped and with sufficient qualified staff to provide them with the necessary assistance*'. The report also recommended that patients should be transferred to hospital immediately when they suffered from extreme mental illness.

43 *Benchmarking Network, Mental health hospital transfer and remission pathways, Analysis of NHS England and NHS Improvement Specialised Commissioning and Health & Justice, and Her Majesty's Prison and Probation Service audits 2019* available at **https://s3.eu-west-2.amazonaws.com/nhsbn-static/Other/2019/Transfers-and-Remissions-28-02-2019-Census-31-10-2019.pdf**

44 Council of Europe, *Report to the Government of the United Kingdom on the visit to Northern Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 29 August to 6 September 2017, December 2018,* available at *09000016808ff5f2 (coe.int)*

4.41 Data confirmed that in almost every case, patients held in Northern Ireland prisons had been transferred to hospital facilities in Northern Ireland. The fact that patients were waiting in a CSU for acute mental health beds, continues to create disparity in treatment between those in prison and those receiving care in the community. Work had been done to reduce the time to effect transfers.

4.42 It is positive that improvements have been made to the physical CSU environments. The work undertaken at Hydebank was a good example of this, but there was no tangible evidence of how such changes had improved prisoner outcomes. Inspectors are not satisfied that the current CSUs in the NIPS have evolved adequately to meet the wide range of needs that they now support. The physical environments and facilities need to be modernised (particularly at Maghaberry and Ash House) and staff at all CSUs need greater investment in training and development. The current women's prison is not designed or built to accommodate a CSU and the accommodation is unsuitable for such a purpose in its present state (see paragraph 4.18).

STRATEGIC RECOMMENDATION 2

The Northern Ireland Prison Service in partnership with the South Eastern Health and Social Care Trust, the Health and Social Care Board and the Department of Health, should urgently review current arrangements to ensure that prisoners suffering from severe mental disorders (including personality disorders, dementia and intellectual disabilities) have equal access to care and treatment in a secure in-patient mental health or learning disability hospital.

The South Eastern Health and Social Care Trust should engage with the commissioners to ensure that future planning for Mental Health provision across Northern Ireland incorporates the needs of the prisoner population, to include agreed pathways for timely access to appropriate hospital beds for those clinically requiring this when experiencing a mental health crisis in a prison setting. The implementation of this recommendation including any actions arising should be overseen by relevant policy leads in the Departments of Health and Justice for consideration by Ministers.

Prisoners are kept safe at all times and individual needs are recognised

4.43 Several individuals held in CSUs were also on the PSST caseload in order that it could fulfil its function to support the most vulnerable prisoners in each prison. Although management of both was now realigned under a single Governor, the Rule 32 reviews, oversight meetings and safer custody reviews still operated in parallel. Consideration should be given to better integrate the review and oversight mechanisms of safer custody and the CSU. Inspectors believe that prisoner outcomes will be improved by bringing these pieces of work together.

4.44 Multiple meetings were held to discuss individual cases within each prison and often required the attendance or contributions from a range of service providers. Inspectors found that they duplicated effort and resulted in care plans that ran in parallel to each other yet seldom producing different outcomes for the prisoners. Inspectors believe that this work can be better integrated, for example, the frequency of meetings at Hydebank resulted in reviews, initial and subsequent oversight meetings, safety and support meetings sometimes following one day after the other. Prisoners reported that the *"goalposts"* kept changing at different meetings and stakeholders had observed that outcomes were influenced by the style and approach of individual Governors who chaired the Rule 32 meetings.

4.45 There were some good examples of individually tailored care plans and serious case reviews. These were mainly for those who presented particularly challenging behaviour or who were mentally unwell. Outcomes for prisoners in these groups was therefore likely to be better than for others.

CASE REVIEW 3: PRISONER A, 29 YEARS, MALE

Segregation was authorised under Rule 35(4) for damaging cell contents and attempting to assault staff during escort to the CSU. It was the eighth period of segregation in the CSU and the third in his current period in custody. There was strong evidence of multi-agency co-operation to care planning based on a detailed understanding of the prisoner's history. This had commenced almost immediately upon his segregation and shortly thereafter, he had been placed on SPAR Evo.[45] Input to care planning was good and had been well documented. Contributors included; the prison psychiatrist, MHT, governors, residential staff, PSST and AD:EPT. The prisoner had remained in the CSU during fieldwork.

4.46 Overall, plans identifying exit and reintegration pathways were inconsistent and in some instances did not exist at all. Inspectors found that when such considerations were made, or where plans existed, they occurred far too long into the segregation period and even during the final days of segregation.

45 Ibid footnote 22.

CASE REVIEW 4: PRISONER E, 45 YEARS, MALE

Prisoner E was placed on Rule 32 for his safety following an alleged altercation with another prisoner on his landing. The incident had not been reported to the prison's security department. The initial period of segregation on Rule 32 was followed by approved extensions for 14, 28 and 14 days. While on Rule 32 there were no oversight arrangements in place and the Rule 32 was reviewed just prior to expiry of the authorised extended periods. No new information was presented at each Rule 32 review. Owing to his vulnerabilities and enemies within the prison, the reviewing Governors had authorised the further segregation periods because they could not identify other available suitable accommodation in the prison. At the last review, the HQ Governor formulated a plan to progress the prisoner from the CSU back to normal location. However, it was not clear from records that the plan had been acted on and Inspectors learned that a final resolution had resulted after the other prisoner involved was relocated within the prison.

Segregated prisoners have daily access to the telephone and a shower and are encouraged to access an equitable range of purposeful activities

4.47 The use of segregation was appropriate in some circumstances but only when used as a last resort. Regardless of the justification, the reality of segregation in the CSU meant that prisoners abruptly stopped the normal way of life experienced by the vast majority of prisoners. Segregation removed prisoners from their peers, their normal living environment and from personal possessions and items important to their daily life.

4.48 Some stakeholders believed that once a prisoner was sent to the CSU that work with them was to pause until their return to normal location. They spoke about a lack of encouragement from some CSU staff and their abruptness in dealing with them. Others spoke in detail about the inadequate facilities, lack of privacy and the oppressive and unwelcoming environment as deterrents directly influencing the continuance of services they provided.

4.49 There was an uncomfortable reliance on a culture that was dependent on the prisoner making a 'Request' for basic needs, such as access to showers, telephone calls and exercise. Although the regimes in each CSU were predictable, they were restrictive and exclusively focused on fulfilling institutional routines. The practice of entitlement by 'Request' worked for some but not for others. Prisoners told Inspectors that this outcome was dictated by the individual's circumstances, such as their state of alertness, ability to understand and experience/knowledge of the process.

4.50 A regime amounted to solitary confinement when a prisoner was confined alone for 22 hours or more a day without meaningful human contact. Inspectors found that no measure of time out of cell was available (see Chapter 3) and that existing arrangements failed to provide complete accurate recording methods of time spent out of cells.

4.51 Multiple CCTV cameras recorded continuous 24 hour activity within the CSUs. Inspectors conducted reviews of recordings from 11 individual days that had been selected by them. The corresponding journals were also reviewed.

4.52 At Maghaberry, the recordings covered a five-day period (weekdays) in January 2021 for landings 1, 2, 3 and 4 (all landings). The CCTV recordings showed that prisoners at Maghaberry spent on average 25 minutes per day out of their cells. This ranged from zero to 87 minutes. Almost half of all prisoners during the period examined (20 of 42) did not leave their cells.

4.53 At Magilligan, the recordings covered a three-day period (two weekdays/one Saturday) in January 2021 for landings A and B (all landings). The CCTV recordings showed that prisoners at Magilligan spent on average 26 minutes per day out of their cells. This ranged from zero to 59 minutes. A quarter of the prisoners during the period examined (two of eight) did not leave their cells.

4.54 At Hydebank, the recordings also covered a three-day period (two weekdays/one Saturday) in February 2021. The situation for young men at Hydebank was better than the other two prisons. The CCTV recordings showed that prisoners at Hydebank spent on average 89 minutes per day out of their cells. This ranged from zero to 3 hours 45 minutes. During the period examined, one of 12 prisoners did not leave their cell and three of 12 had been out for longer than two hours.

4.55 Female prisoners were observed cleaning when out their cells, using the telephone and yard, but it was not possible to establish the full duration of time out of cell from the CCTV recordings reviewed.

4.56 CCTV recordings represented a small snapshot and all dates reviewed were during the period of COVID-19 pandemic restrictions. The reviewed recordings served to illustrate that at each site, some prisoners spent long periods locked in their cells. The outcomes for individuals varied considerably depending whether they chose to engage in daily routines and/or had other appointments to attend.

4.57 It was evident from the CCTV recordings that CSU staff facilitated multiple telephone calls for individual prisoners. Based on the evidence obtained during interviews with over 170 prisoners, staff and stakeholders, a restricted regime, the lengthy periods of detention under Rule 32, incomplete/inadequate records and a review of CCTV recordings, Inspectors concluded that many prisoners were being kept locked for long periods each day.

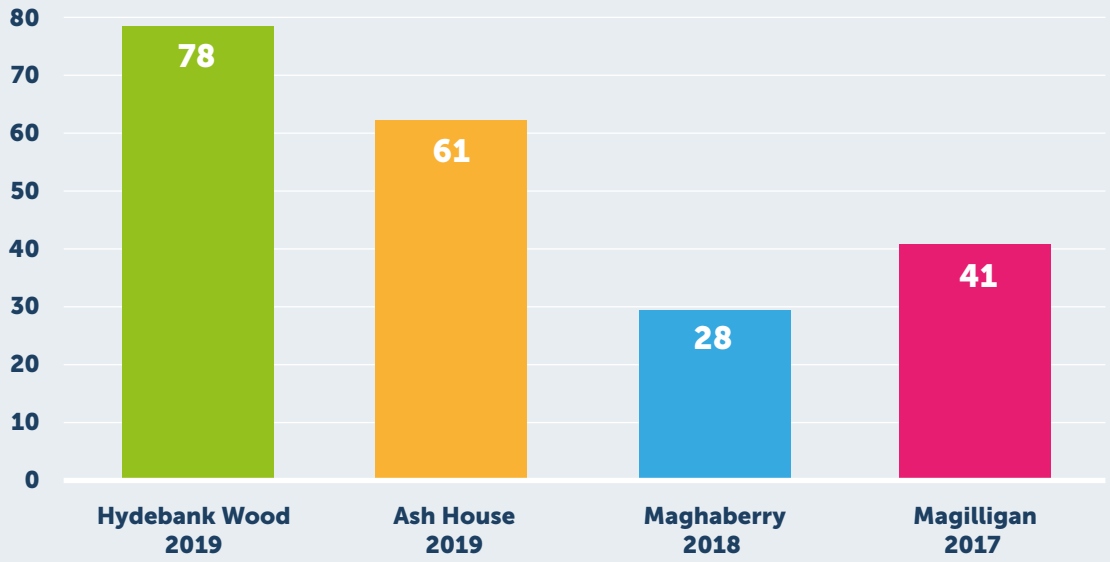
4.58 A lack of detailed recording of routine interactions with prisoners made it extremely difficult to assess the level of meaningful contact between prisoners and others. Most prisoners said they had very little contact with staff outside the routine visits for requests, meals, or Governor visits. Prisoners, stakeholders and service providers consistently cited lack of privacy (presence of prison staff at cell unlock) and poor CSU facilities as reasons why they were unable to have meaningful contact with others.

4.59 Prior to the COVID-19 pandemic service providers reported that 90% of conversations with those in CSUs took place at cell doors in the presence of CSU staff. There was a particular issue of perception of the CSU at Maghaberry where several service providers reported that the atmosphere was not welcoming. One told Inspectors, *"In terms of the atmosphere and with the staff too that there was quite an undertone of aggression."* Inspectors believe that the NIPS should take urgent remedial action on these points of learning.

4.60 Some behavioural logs and SPARs reviewed by Inspectors had recorded details about conversations with an individual. Staff said that they encouraged and supported some individuals, for example, in relation to mental health, personal hygiene, taking exercise or phoning family. Inspectors saw examples of that during fieldwork. Interactions viewed on CCTV recordings were brief and appeared functional although there was no audio recording.

4.61 Personal Officers were Prison Officers assigned to act as a key point of contact and to provide help and support to prisoners. Some Personal Officers in the CSU possessed good understanding of individual prisoners. Surveys[46] conducted at all full inspections prior to fieldwork provided mixed feedback. Responses captured positive prisoners' outcomes by asking if Personal Officers had been very helpful, quite helpful or helpful. At Hydebank, 78% of respondents indicated that their experience had been positive while at Maghaberry, it was just 28%. Prisoner feedback during fieldwork for this review was also mixed in relation to knowledge of and positive engagement with their Personal Officers while in a CSU.

Chart 4: HMIP survey results showing percentage of positive prisoner outcomes with personal officers



46 HMIP surveys are based on stratified random samples of the prison population and the results and methodology are appendices to each inspection report.

4.62 The role of Personal Officers took on added significance for segregated prisoners in the CSU and for those with responsibilities for their segregation. Operational procedures on entering the CSU should ensure that prisoners are formally advised and that they understand who their Personal Officers are and this should be documented.

4.63 Some good examples of conversations with prisoners were recorded on body worn camera recordings at Maghaberry. Prisoners and staff used first names and the interactions were respectful with staff providing, calm, supportive and measured responses. There was also one example at Maghaberry where an individual Prison Officer spent time on multiple occasions speaking with a prisoner who was on a SPAR Evo, although the conversations were conducted through the flap on the cell door. In Chapter 3, Inspectors have discussed the visits by Duty Governors and health care and the impact of COVID-19 on engagement from service providers such as the IMB and chaplains that had stopped altogether for a period.

4.64 Operating procedures permitted the assessment of suitability for prisoner to prisoner association, however Inspectors did not find any evidence that this occurred. Prisoners stated that they could shout to others but no association with other prisoners was permitted.

4.65 The pandemic had forced some restrictions on wider engagement, but evidence from before COVID-19 restrictions strongly reinforced the fact that it was the environment and perceptions of the CSU at Maghaberry and its staff that were long-term hurdles to improving the quality and level of engagement with prisoners. Inspectors also received positive comments from service providers that recent staff changes at Maghaberry were bringing some initial improvements for prisoners. The arrangements had not been in place sufficiently long for Inspectors to make any long-term findings on these outcomes.

4.66 Data collected by senior managers across the prisons showed a high level of need, as evidenced by very low levels of prior educational attainment or history of employment. Learning and skills delivery in prison can positively influence outcomes for individuals post-release and can increase the likelihood of finding employment in the community. Some prisoners who had previous experience of, or were currently in a CSU, told Inspectors that they wanted and would welcome the opportunity to continue learning and skills work while in the CSU. These prisoners recognised that this would have helped them to deal with the boredom when in the Unit. It is essential that the NIPS provide appropriate opportunities to segregated prisoners in the CSUs so that they, like others held in prison, are enabled to participate in learning and skills.

4.67 The NIPS needed to ensure that resources provided to all CSUs took much greater cognisance of the low levels of literacy and numeracy skills among the majority of the general prison population to support satisfactory prisoner development for these essential skills. Those not engaged in learning and skills prior to segregation in a CSU needed clear pathways to do so. In this regard, all staff played a key role to encourage and support prisoners. Prison Officers working in CSUs, PDU Co-ordinators, PSST officers and staff from Belfast Met and NWRC were pivotal to the success of this.

4.68 Of the 12 case reviews conducted by Inspectors, there was only one example of a prisoner having attended an offending behaviour programme or a rehabilitative service. Service providers told Inspectors that individuals were deselected from programmes/activities due to the length of time they spent in the CSUs and planned contacts with specialist workers were interrupted. There was also debate among service providers about whether the current CSU environment was conducive to undertaking therapeutic work and of the readiness of individuals to engage given their current circumstances. Others expressed the view that it presented an opportunity to support individuals, stabilise and ready them to engage after leaving the CSU. Inspectors consider that the provision of these services should not stop or be deferred because a prisoner is in the CSU.

4.69 As with time out of cell, no baseline position for purposeful activity within the CSUs had been set. In 2019[47] Inspectors welcomed the commitment to '*define the scope of purposeful activity and establish the baseline position at each establishment*' under the NIPS *Prisons 2020* programme. It is recommended that this definition take account of areas recommended in the previous Safety of Prisoners inspection report.

4.70 Overall Inspectors conclude that those in segregated conditions do not have access to an equitable range of purposeful activities and this is further exacerbated by the restrictions imposed because of the COVID-19 pandemic.

STRATEGIC RECOMMENDATION **3**

The Northern Ireland Prison Service, in partnership with Belfast Metropolitan College, within six months of the publication of this report, should ensure that men and women who are held in Care and Supervision Units have equitable access to purposeful activity including learning and skills, library services and physical activity and that engagement in these activities is proactively encouraged and facilitated.

47 *CJI, The Safety of Prisoners held by the Northern Ireland Prison Service, November 2019* available at **http://www.cjini.org/getattachment/3a70dd41-7bb3-430d-9901-3ed7a191cf94/report.aspx**

4.71 Evidence from the review of CCTV recordings and observations during fieldwork, interviews with prisoners, staff and stakeholders together with the lack of peer association, purposeful activity and in particular, access to learning and skills, raised significant concerns about the treatment of prisoners in the CSUs. The records examined by Inspectors failed to dispel wider evidential concerns about the length of time prisoners spent in their cells and the lack of meaningful human contact with them. In the absence of effective assurance, Inspectors concluded that a number of prisoners in Care and Supervision Units had experienced conditions amounting to solitary confinement (as defined by the Mandela Rules). Even those who made regular telephone calls and accessed the yards or had other appointments to attend were unlikely to be out of their cells for more than two hours per day. This depended on how many prisoners needed to make use of the available facilities at any one point in time. If landings were fuller than when fieldwork was conducted, it seems unlikely that the CSUs would have the capacity to fulfil even the most basic requirements.

Equality

4.72 Prisoners punished with cellular confinement were normally segregated in the CSU. Women were treated differently and had been accommodated in Ash House until the opening of the new joint CSU in 2020. Data for the period 2015-2020 (six years) consistently showed that a higher percentage of Catholics than Protestants were segregated by cellular confinement at each prison.

Table 2: Religious breakdown 2015-2020 (six years) – cellular confinement in a CSU

	% Maghaberry		% Magilligan		% Hydebank Wood		% Ash House		% Total	
	Pop	**CSU**	**Pop**	**CSU**	**Pop**	**CSU**	**Pop**	**CSU**	**Pop**	**CSU**
Protestant	28	26	32	26	22	23	27	37	29	26
Catholic	53	65	54	64	60	67	52	49	53	65
Other	19	9	14	10	18	10	21	14	18	10

4.73 Across the sampled six-year period, this was 65% (769 of 1,192) for Catholics, which was 12% above the Catholic population for the whole prison (53% =14,797 of 27,743). For Protestants the figure was 26% (306 of 1,192), which was almost equal to the Protestant population for the whole prison (29% = 7,908 of 27,743). The percentage of Catholic prisoners segregated by cellular confinement was highest at Hydebank Wood at 67% (141 of 212) and Ash House was lowest at 49% (17 of 35). Table 2 provides a breakdown for all prisons.

4.74 However, a 2019 report published by Queens University, Belfast - '*Explaining Disparities in prisoner outcomes*'[48] - concluded that when the influence of other individual, societal and prison related variables were considered alongside religion for the number of adjudication charges, guilty adjudications verdicts and PREPs regime level, the differences between Catholics and Protestants was no longer statistically significant.

4.75 The NIPS should continue to carefully monitor the impact of its decisions on all Section 75 of the Northern Ireland Act 1998 (s.75) groups of prisoners. The CJI inspection of the implementation of s.75 within the criminal justice system had urged inspected agencies, including the NIPS, to '*review their section 75 monitoring arrangements in relation to relevant functions' and develop actions to address gaps in section 75 monitoring and explain any disparities identified (Strategic Recommendation 2)*.[49] Having completed fieldwork for this inspection, Inspectors conclude that NIPS decision-making in relation to prisoners it placed on cellular confinement in a CSU is an important function that should be included within its s.75 monitoring arrangements.

48 *Queens University Belfast: Explaining Disparities in Prisoner Outcomes. Report by Butler, M., Kelly, D., & McNamee, C. 2019*, available from *Queens University.*

49 *CJI, Equality and Diversity within the Criminal Justice System: An Inspection of the Implementation of Section 75 (1) of the Northern Ireland Act 1998, September 2018*, available at, **https://www.cjini.org/getattachment/f2f58a1f-a9f3-449f-a684-567b6db4c667/report.aspx**

APPENDIX 1: METHODOLOGY

Inspectors requested and were provided with a wide range of data by the Northern Ireland Prison Service before (NIPS), the South Eastern Health and Social Care Trust (SEHSCT), Belfast Metropolitan College (Belfast Met) and North West Regional College (NWRC). To facilitate longitudinal trend analysis, Inspectors obtained data covering the period January 2011 to 30 November 2020.

Prisoners were selected for interview and case reviews from lists of those currently segregated in a CSU or were randomly selected from anonymised five-year datasets (2015-2020) of those who had been held on Rule 32, Rule 35(4) and cellular confinement.

Inspectors used semi-structured interviews with prisoners. These explored their experience of segregation and included the circumstances that had led to their segregation, conditions while segregated, daily regime and treatment by staff and stakeholders.

Inspectors conducted in-depth case reviews of 12 cases. The case reviews examined the circumstances leading to segregation in a CSU, initial segregation decisions, engagement, monitoring and review, regime, purposeful activity, health care and mental health needs, care planning, reintegration, decision making and outcomes following a period of segregation.

Inspectors also conducted individual and group semi-structured interviews with staff involved in the supervision and care of prisoners who were in the CSU. They focused on staff working in and providing support to the operation of a CSU. This included staff from the SEHSCT, the Belfast Met and NWRC who were also interviewed.

Inspectors observed prisoners segregated in all CSUs and inspected the conditions and facilities at each site. Duty Governor's daily visits, Rule 32 reviews and oversight meetings at each prison were also observed. Photographs were taken of the physical environment during fieldwork.

CSU staff completed a daily hand written journal (known as a Class Officer, Senior Officer or Night Guard journal). Inspectors reviewed 201 daily entries made in these journals across the three sites from 2016-2020 inclusive. Closed Circuit Television (CCTV)[50] recordings were examined for 11 days in January and February 2021 along with the corresponding journals. A small selection of Body Worn Camera recordings were also viewed at Maghaberry and Hydebank.[51]

50 *Closed Circuit Television (CCTV) - records video content but cannot record audio content*
51 *Body Worn Camera records video and audio content when activated by staff*

Inspection framework

The review was conducted using HMIP's *Expectations* for men and women[52] and The Quality Standards for Health and Social Care Supporting Good Governance and Best Practice in the HPSS.[53] At the time of this review, HMIP had been consulting on introducing specific Leadership Expectations.[54]

HMIP *Expectations* set out the criteria the HMIP use to inspect prisons and are designed to promote treatment and conditions in detention, which at least meet recognised international human rights standards.[55] Segregation of adult men and women is assessed under the healthy prison area of 'safety' (see Appendix 3). Each Expectation has indicators that suggested evidence that an Expectation has been achieved. The list of indicators was not exhaustive and prisons could demonstrate the Expectation had been met in other ways.

52 *This review utilised version 1 of the Women's Expectations which was subsequently updated by version 2 in April 2021* available at **https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2021/08/Womens-Expectations-FINAL-July-2021-1.pdf**

53 *DHSSPS, The Quality Standards for Health and Social Care, Supporting Good Governance and Best Practice in the HPSS, March 2006* available at **https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/the-quality-standards-for-health-and-social-care.pdf**

54 *HMI prisons, Consultation on Expectations for leadership, March 2021* available at **https://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/expectations-for-leadership/?highlight=leadership%20expectations**

55 *HMI Prisons, Our Expectations* available at **http://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/children-and-young-phttps://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/**

APPENDIX 2: TERMS OF REFERENCE

A REVIEW INTO THE OPERATION OF CARE AND SUPERVISION UNITS IN THE NORTHERN IRELAND PRISON SERVICE

TERMS OF REFERENCE

Introduction

A review of the operation of Care and Supervision Units (CSUs) in the Northern Ireland Prison Service (NIPS) is to be undertaken by Criminal Justice Inspection Northern Ireland (CJI) in partnership with the Regulation and Quality Improvement Authority (RQIA) and the Education and Training Inspectorate (ETI).

This review follows a request from the Minister of Justice (the Minister), Naomi Long MLA, to the Chief Inspector of CJI on 9 November 2020 that has been agreed to.

The announced review followed online reports[56] in October and November 2020 that raised concerns about the operation of CSUs including the use of solitary confinement and allegations of ill treatment. The Minister indicated that she and the Director General of the Northern Ireland Prison Service were concerned to ensure public confidence in the work of the NIPS was not undermined. The Minister later announced, *"that due to the nature and purpose of these Units, it is important that periodic reviews are carried out into their use in our prisons".*[57]

Context

CJI is an independent statutory Inspectorate that reports on the treatment and conditions of those detained in prisons within Northern Ireland. The RQIA is an independent non-departmental public body responsible for monitoring and inspecting the quality, safety and availability of health and social care services across Northern Ireland. Both organisations are members of the National Preventive Mechanism (NPM).[58] The ETI is part of the Department of Education and provides independent inspection services on the quality of education.

56 The Detail - *Justice and Crime*, available at **https://www.thedetail.tv/investigations/solitary-confinement-69474e8b-5958-4b72-96fa-40169226f81d**

57 DoJ website - *Long announces review of prison care and supervision units,* November 2020, available at **https://www.justice-ni.gov.uk/news/long-announces-review-prison-care-and-supervision-units**

58 National Preventive Mechanism Website, available at **https://www.nationalpreventivemechanism.org.uk/**

All inspections carried out by CJI in partnership with the RQIA contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).[59] OPCAT requires that all places of detention are visited regularly by independent bodies known as the NPM in order to monitor the treatment of and conditions for detainees.

In response to statutory and NPM obligations, Northern Ireland prisons are inspected as part of the CJI inspection programme. They are conducted in partnership with the United Kingdom's national co-ordinator for the NPM, Her Majesty's Inspectorate of Prisons (HMIP), together with CJI, the RQIA and the ETI. The inspections examine four tests for a healthy prison using sets of *Expectations*[60] developed by HMIP and The Quality Standards for Health and Social Care Supporting good governance and best practice in the HPSS (March 2006) used by the RQIA that are specifically focused on health care provision. Such inspections are normally unannounced and CSUs are included as part of that full inspection process. Unlike full inspections, this review will focus on the operation of CSUs and as previously indicated, it has been announced by the Minister.

The Prison and Young Offenders Centres Rules (Northern Ireland) 1995 set out a number of circumstances when the prison Governor[61] may arrange for restrictions of association (Rule 32), the keeping apart from other prisoners (Rule 35) and the use of cellular confinement (Rule 39).[62] It should be noted that a decision to apply such rules does not automatically result in the relocating of a prisoner to CSU accommodation.

There are four CSUs in Northern Ireland based at Maghaberry Prison, Magilligan Prison, Hydebank Wood Secure College (for young men) and at Ash House Women's Prison. CSUs provide accommodation that is separate from other parts of the prison used by the prisoner population.

A new CSU was opened for women at Ash House Women's Prison at Hydebank Wood on 5 October 2020. Prior to that date there had been no specifically designed accommodation designated for female prisoners like that described for the detention of male prisoners. In the absence of such accommodation, and when the relevant rules had been applied to female prisoners, the existing female accommodation had been utilised instead.

59 Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) available at **https://www.ohchr.org/EN/ProfessionalInterest/Pages/OPCAT.aspx**

60 Her Majesty's Inspectorate of Prisons website - *Our Expectations*, available at **https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/**

61 Status of Governor - '*The Governor shall be in command of the prison*,' Statutory Rules of Northern Ireland No.8. *The Prison and Young Offenders Centres Rules (Northern Ireland) 1995*, available at **https://www.justice-ni.gov.uk/sites/default/files/publications/doj/prison-young-offender-centre-rules-feb-2010.pdf**

62 Statutory Rules of Northern Ireland No.8. *The Prison and Young Offenders Centres Rules (Northern Ireland) 1995*, available at **https://www.justice-ni.gov.uk/sites/default/files/publications/doj/prison-young-offender-centre-rules-feb-2010.pdf**

Aims of the CSU Review

The broad aims are to:

- review and assess the effectiveness of strategic oversight and governance arrangements;
- review current policies, practices and procedures relating to CSUs and assess their application and impact on prisoner treatment, well-being and conditions;
- examine and identify outcomes for prisoners relocated to CSUs under Rules 32, 35 and 39 and for those not relocated but for whom the same rules have been applied;
- evaluate the effectiveness of relevant performance management mechanisms; and
- establish how good practice influences continuous improvement, including the implementation of previous CJI inspection recommendations.

Other matters of contextual significance as they arise during the review will be considered.

COVID-19 pandemic

The review will be undertaken in compliance with the Northern Ireland Assembly's regulations to control the spread of COVID-19. Restrictions on travel and social distancing will be kept under constant review. When appropriate and in order to reduce risk through human contact, consideration will be given to use of available technology.

However, this review requires on site fieldwork and evidence gathering. Inspectors will attend each prison site (Maghaberry, Magilligan and Hydebank Wood). Measures to prevent the spread of infection, such as the wearing of Personal Protective Equipment will be strictly adhered to by the review team under the guidance of the RQIA.

Every reasonable effort will be taken to conclude fieldwork within the indicative timings below, however, each stage of the review will be subject to risk reviews.

Methodology

The review will be conducted by CJI in partnership with the RQIA and the ETI and will draw on the HMIP's *Expectations* for segregation and the RQIA's expectations for health care provision. The Review Team partnership will examine the operation of CSUs at Maghaberry Prison, Magilligan Prison, Hydebank Wood Secure College (for young men) and Ash House Women's Prison at Hydebank Wood.

CJI will liaise with HMIP, as part of existing arrangements to promote conditions for detainees and to increase OPCAT compliance, as required and agreed.[63]

The review will be based on the CJI Inspection Framework consisting of three main elements: *Strategy and governance, Delivery* and *Outcomes*. CJIs Inspection Processes, Inspection Framework and Operational Guidelines are available at **www.cjini.org.**

63 HMIP Inspection Framework, available at **https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/03/INSPECTION-FRAMEWORK-2019.pdf**

The Review Team

- *CJI* - inspect to secure improvement and to promote greater co-operation between the various statutory and voluntary organisations to provide a better justice system for the whole community in Northern Ireland.
- *RQIA* - are the health and social care regulator in Northern Ireland and inspect to provide assurance about the quality of care, challenges poor practice, promotes improvement and safeguards the rights of service users. RQIA will act in compliance with its Escalation Policy and Procedures if required. Further information on practice and policy is available at **www.rqia.org.uk/.**
- *ETI* - inspect to promote the highest possible standards of learning, teaching, training and achievement throughout the education, training and youth sectors in Northern Ireland. Further information on practice and policy is available at **www.etini.gov.uk/.**

Design and planning

Inspectors will identify, consider and analyse best practice, national guidance, policies and standards from other jurisdictions. Benchmarking may also be undertaken against comparators in best practice jurisdictions and similar service providers. Reading, analysing and reviewing other relevant reports, business plans, websites, strategies, action plans, relevant academic research, previous inspection reports, documentation and data is also undertaken.

Delivery

- Terms of Reference will be provided to the Department of Justice (DoJ), the NIPS, the South Eastern Health and Social Care Trust (SEHSCT), the Belfast Metropolitan College and North West Regional College, prior to the commencement of the review.
- The NIPS, the SEHSCT, the Belfast Metropolitan College and North West Regional College should appoint Liaison Officers to support the partnership in conducting the review.
- Management information, data and documentation will be requested from the relevant organisations.
- A review of relevant paper-based case files and records held electronically will be conducted.
- Interviews and focus groups will take place with staff in the NIPS, the SEHSCT, the Belfast Metropolitan College and North West Regional College.
- Interviews and focus groups will take place with prisoners and relevant stakeholders.
- CSUs and other relevant prison environments will be inspected and observations recorded. Photographs taken and published will be in accordance with agreed inspection guidelines.

Completion of fieldwork

Following completion of fieldwork, analysis of data and the presentation of emerging findings to the NIPS, the SEHSCT, the Belfast Metropolitan College and North West Regional College, a draft report will be provided for the purpose of factual accuracy checking. The inspected organisations will be invited to complete an action plan to address any recommendations. Action plans will be published as part of the final review report. The review report will be shared, under embargo, in advance of the publication date with the DoJ, the NIPS, the SEHSCT, the Belfast Metropolitan College and North West Regional College.

Publication and closure

The review report is scheduled to be completed by June 2021. Once completed it will be sent to the Minister for permission to publish. When permission is received the report will be finalised for publication. The report is likely to contain recommendations along with identified good practice that are focused on continual improvement. Any CJI press release will be shared with the DoJ, the NIPS, the SEHSCT, the Belfast Metropolitan College and North West Regional College prior to publication and release. A suitable publication date will be agreed and the report then made public on all partnership websites.

Indicative timetable

A proposed timetable is as follows and will be subject to ongoing review.

2020	**November/December**	Research and Terms of Reference
2021	**January/February**	Fieldwork/case file review
2021	**March/April**	Drafting of report
2021	**May**	Factual Accuracy feedback from NIPS/SEHSCT/Belfast Met/NWRC
2021	**June**	Publish report

Organisations will be kept advised of any significant changes to the indicative timetable.

APPENDIX 3: HMIP EXPECTATIONS FOR SEGREGATION OF MEN AND WOMEN

MEN'S PRISON EXPECTATIONS

Expectation 9 - Prisoners are only segregated with proper authority and for the shortest period.

The following indicators describe evidence that may show this expectation being met, but do not exclude other ways of achieving it:

- Prisoners are not segregated except as a last resort, for as short a time as possible and subject to proper authorisation.
- Prisoners with severe mental illness and prisoners at risk of suicide or self-harm are not segregated except in clearly documented exceptional circumstances on the authority of the governor.
- Prisoners are informed of the reasons for their segregation in a format and language they understand.
- Transfers of prisoners between segregation units are exceptional, carefully monitored to prevent prolonged segregation and properly authorised.
- A multi-disciplinary staff group monitors prisoners held in segregation units to ensure they are held there as a last resort and for the shortest possible time.

Expectation 10 - Prisoners are kept safe at all times while segregated and individual needs are recognised and given proper attention.

The following indicators describe evidence that may show this expectation being met, but do not exclude other ways of achieving it:

- There is a clear focus on meeting individual need and providing care and support for segregated prisoners.
- Health staff promptly assess all new arrivals in the segregation unit and contribute to care plans.
- Segregated prisoners receive assertive mental health support and regular review.
- Prisoners are never subjected to a regime which amounts to solitary confinement (when prisoners are confined alone for 22 hours or more a day without meaningful human contact).
- Prisoners have meaningful conversations with a range of staff every day, including the opportunity to speak in confidence with a senior manager, a health care professional and a chaplain.

- Staff are vigilant in detecting signs of decline in mental health, mitigate the social isolation inherent in segregation and actively seek alternative locations.
- Reviews are multidisciplinary and prisoners are able attend.
- Staff are appropriately trained and supported and receive specialist supervision from a trained facilitator.
- Efforts are made to understand and address the behaviour leading to segregation.
- Prisoners in the segregation unit are not strip- or squat-searched unless there is sufficient specific intelligence and proper authorisation.
- The number of staff necessary to unlock individual men in segregation is decided on the basis of a daily risk assessment, which is properly authorised and recorded.

Expectation 11 - Segregated prisoners have daily access to the telephone and a shower and are encouraged to access an equitable range of purposeful activities.

The following indicators describe evidence that may show this expectation being met, but do not exclude other ways of achieving it:

- The regime is tailored to individual need, prisoners know what regime to expect and they have the opportunity to use the telephone every day.
- As a minimum prisoners have one hour of outside exercise every day.
- Prisoners located on the segregation unit long term have a care plan and are encouraged and supported to associate with others and to return to normal location.
- Prisoners are provided with extra care and support after a period of isolation with a view to preventing future episodes.
- Prisoners have appropriate activities to occupy and stimulate them in their cells.
- Subject to risk assessment, prisoners can access the same facilities and privileges as elsewhere in the prison and can access regime activities and peer supporters.
- Prisoners have access to outside exercise and other activities together, subject to appropriate risk assessment.

WOMEN'S PRISON EXPECTATIONS[64]

Expectation 29 - Women are kept safe at all times while segregated and individual needs are recognised and given proper attention.

Indicators

- Women are segregated only with proper authorisation and for appropriate reasons.
- A safety algorithm is completed by a member of health care staff within two hours of segregation.
- There is a clear focus on providing care and support.
- Cells used for segregation are fit for purpose, well maintained and clean.

64 *HMI Prisons published version 2 of their women's Expectations in April 2021. The excerpt provided in Appendix 3 is from version 1 and was current at the time of the review.*

- Women on an open ACCT, or women needing separation for non-punitive reasons, such as those with complex needs, are not held in the segregation unit except in exceptional circumstances, which are documented, and agreed by a senior manager. Such decisions are part of a care planned approach to meet the woman's needs in a more appropriate environment. Segregated women are searched thoroughly and respectfully. Strip searches are only conducted where the need has been identified through risk assessment.
- The number of staff necessary to unlock individual women in segregation for control purposes is decided on the basis of a daily risk assessment.
- Transfers of women prisoners from one segregation unit to another are exceptional and only take place when authorised by the governors of the sending and receiving establishments or the deputy directors of custody.
- A multidisciplinary staff group monitors adherence to the prison service order on segregation. Particular care is taken when women are segregated on residential units. There is evidence that they are satisfied that the staff culture supports the aim of individual management and care for segregated women. Regular monitoring and reports for the governor and deputy director of custody include:
  - the numbers segregated (in whatever location)
  - the length of stay
  - individual reports on those held for less than three months
  - the use of CC as punishment
  - the use of personal protective equipment
  - the proportion of all protected characteristics under adjudication and in segregation
  - the number failing the algorithm
  - the number on open ACCT processes and levels of self-harm
  - the number of upheld complaints
  - the number of segregation-to-segregation transfers
  - the use of special accommodation.

Expectation 30 - Women are segregated safely and decently for the shortest possible period and are supported to reintegrate into the normal regime at the earliest opportunity.

Indicators

- A prisoner's segregation status is reviewed within 72 hours and then at least every fortnight by a multidisciplinary review group, chaired by a governor
- Review timings are determined at the initial review and take account of individual circumstances.
- Segregated women are actively involved in the review process.
- Staff attending review boards offer individual contact with the prisoner between reviews and are aware of the prisoner's individual needs.
- Segregated women are provided with the opportunity to speak to a senior manager out of the hearing of staff on request.
- Women have daily access to a senior manager, chaplain and a health services professional, in private if requested, and a record of these visits is maintained. A member of the Independent Monitoring Board (IMB) team visits at least once a week.

- All staff make daily, detailed records of prisoner's behaviour on individual history files and/or monitoring forms. Wing staff maintain regular contact with women segregated under Rule 45 to facilitate their return to normal location.
- All staff having contact with a segregated prisoner record relevant details of their contact in individual history files.
- Segregated women who have been assessed as meeting the criteria for transfer to a secure mental health facility under the Mental Health Act do not wait more than 14 days for such a move. In the meantime, they are supported by mental health services staff.
- IMB representation is specifically invited, with adequate notice, for all good order or discipline (GOOD) reviews.
- Staff are appropriately trained and, as a minimum, custody staff are trained in de-escalation, equality and diversity, suicide prevention, mental health, personality disorder and motivational interviewing.
- Staff are aware of the policy relating to temporary separation of women and related governance arrangements.
- The prison has a published staff selection policy for the segregation unit, and those selected have been personally authorised by the governor and trained for their role.
- There is an appropriate gender mix of staff working with segregated women.

Expectation 31 - Segregated women understand the reasons for their segregation, the Rules and regime available to them and how to access activities.

- Women are informed of the reasons for their segregation in writing, in a format and language they can understand.
- Women understand the Rules and regime which apply to them.
- A statement of purpose is prominently displayed in any segregation unit with pictures of the multi-disciplinary team who review segregation.

Expectation 32 - Women are encouraged and enabled to access a range of purposeful activities during their time in the segregation unit. They have access to the same range of activities, facilities and services as women on normal location.

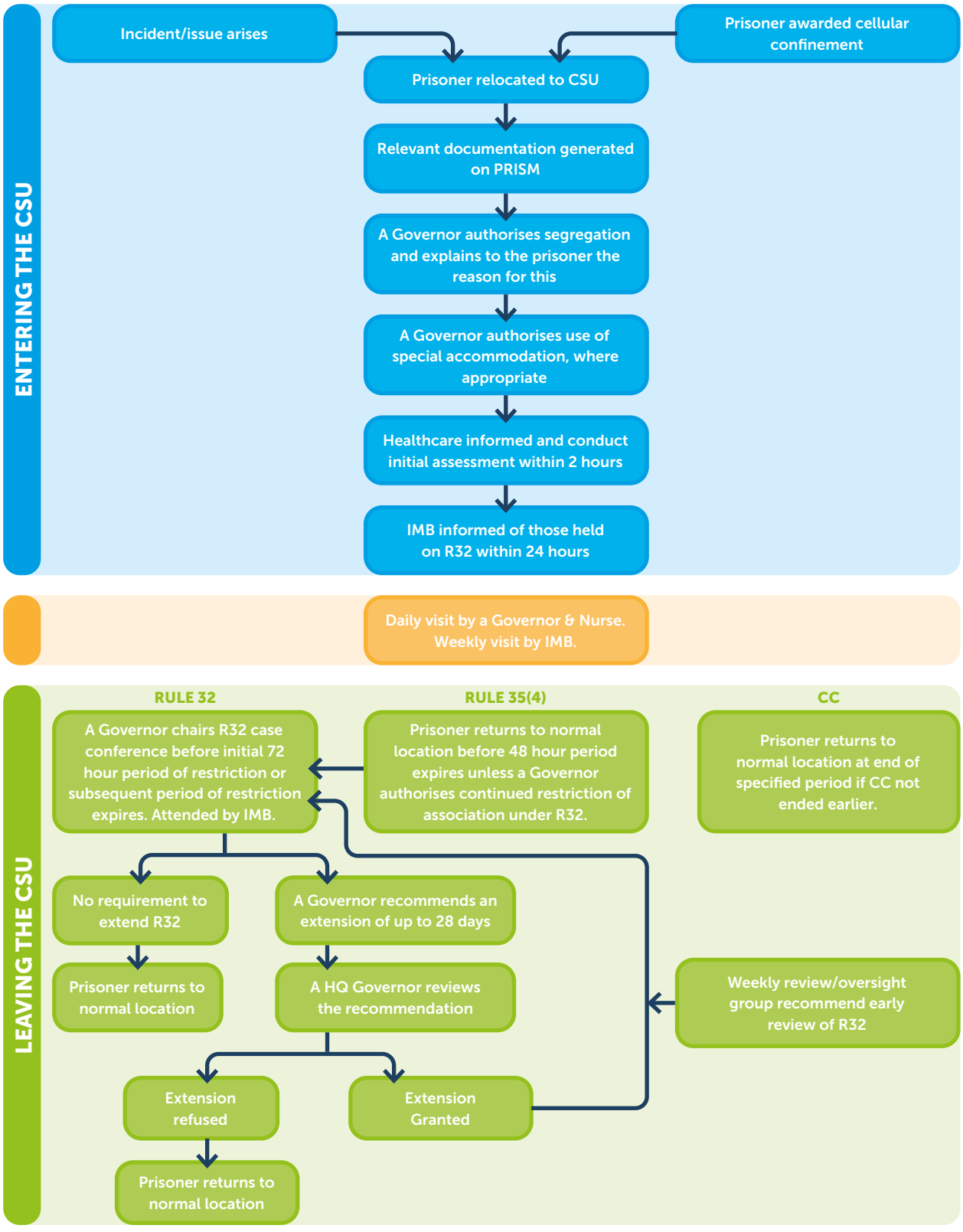
Indicators

- Equal access to activities, facilities and services include: - telephone and visits - showers - outside exercise for at least an hour every day - canteen and approved property (unless temporarily applied as an adjudication punishment) - the incentives and earned privileges scheme - meals collected from a servery wherever possible.
- Women are provided with appropriate activities to occupy and stimulate them in their cells. Women located on the segregation unit long-term have a care plan put in place after four weeks to prevent psychological deterioration.
- Within the constraints of security and good order, women have reasonable access to activities, which include:
  - the library
  - education

  - in-cell exercise
  - work
  - religious services
  - offending behaviour programmes
  - counselling.

- The regime in segregation never falls below a basic level regime.
- Women are able to attend mainstream activities where a risk assessment allows, and phased returns are used to encourage women to return to normal location.
- Women have access to outside exercise and association with other women unless a risk assessment suggests this is inappropriate.

APPENDIX 4:
PROCESS OVERVIEW FLOWCHART FOR ENTERING AND EXITING CARE AND SUPERVISION UNITS
(AS AT 22 MARCH 2021)



APPENDIX 5: CARE AND SUPERVISION UNIT ACCOMMODATION AND FACILITIES
(AS AT 22 MARCH 2021)

Facilities	Maghaberry	Magilligan	Hydebank Wood Secure College	Hydebank Wood Women's Prison
Total number of cells	30	14	16	4
Special accommodation – *use must be authorised by a Governor and individual observation log maintained*				
Observation (safer) cells	2	1	1	✗
Recovery room/cell	1	✗	2	✗
Dry cell	2	1 (also used for searching)	✗	✗
Designated dirty protest cells	✓ accommodation designated as required	✓ accommodation designated as required	✗	✗
Calm room	✗	✗	1	✗
Adjudication room	1	1	1	
Interview room	1	1	1	
Telephone booths	2	✗ Telephone on B wing	1	
Association room	✗	✗	Multi-purpose room - servery, seating, TV, game console, piece of gym equipment and library	
Shower room/ ablutions	1 on upper and lower floors	1	1	
Exercise yard	2	1	1	
Exercise equipment in yard	✓	✓	✗ table tennis table	
In-house gym	✓	✗ 1 piece of gym equipment on B wing	✗ 1 piece of equipment in recreation room	
Sensory garden	✗	1	✗	
Health care room	1	1	✗ on landing above	
Video conferencing facilities	✗	✗	✗	
Access to Library books (in-house)	✓ limited range	✓ limited range	✓ wider range and access to a mobile library unit	

Definitions

Observation cell - used to keep a prisoner safe from their own actions in accordance with NIPS Suicide & Self-Harm Policy and SPAR Evolution Operating Procedures.

Recovery cell - a cell equipped to aid the retrieval of any unauthorised or prohibited articles concealed internally by a prisoner.

Dry cell (Maghaberry only) - a bare unfurnished cell without normal furniture, fittings, bedding or clothing used to aid the retrieval of any unauthorised or prohibited articles concealed internally by a prisoner.

Designated dirty protest cell - a cell designated when required to hold prisoners to be managed under the NIPS Dirty Protest Faecal Contamination Policy.

Calm room - a short stay room used to de-escalate a prisoner coming onto the CSU who exhibits signs of aggression. It is not designed for overnight stay and has no overnight furniture.

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