The Treatment of Vulnerable Prisoners by the Northern Ireland Prison Service

A follow-up review of inspection recommendations

January 2012

Criminal Justice Inspection
Northern Ireland
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Contents

List of abbreviations

ASIST	Applied Suicide Intervention Skills Training
CAMHS	Child and Adolescent Mental Health Services
CAB	Challenging Anti-Social Behaviour policy
CBT	Cognitive Behaviour Therapy
CJI	Criminal Justice Inspection Northern Ireland
CSU	Care and Supervision Unit
HMIP	Her Majesty's Inspectorate of Prisons in England and Wales
NCO	Night Custody Officer
NIPS	Northern Ireland Prison Service
POA	Prison Officers' Association
PRISM	Prison Record and Inmate System Management
PSMB	Prison Service Management Board
REACH	Reaching out through Engagement, Assessment, Collaborative working and Holistic approach
RQIA	Regulation and Quality Improvement Authority
SEHSCT	South Eastern Health and Social Care Trust
SPAR	Supporting Prisoners At Risk process/document
YOC	Hydebank Wood Young Offenders' Centre

Chief Inspector's Foreword

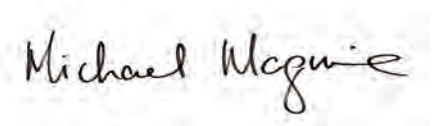
In December 2009 Criminal Justice Inspection published a report on the treatment of vulnerable prisoners by the Northern Ireland Prison Service (NIPS). The purpose of the inspection – requested by the then Minister of Justice – was to assess the treatment of vulnerable prisoners six months after the Prisoner Ombudsman's Report into the death in custody of Colin Bell (and one year after the death of Mr Bell); and six months after the joint CJI/Her Majesty's Inspectorate of Prisons (HMIP) unannounced inspection of Maghaberry Prison which raised significant concerns over the safety of prisoners.

This report is a follow-up inspection which considers the extent to which the recommendations presented in the December 2009 report have been implemented. The conclusion is that progress has been made in relation to the treatment of vulnerable prisoners and that the NIPS has taken steps to address the deficiencies identified in the previous reports. In particular the implementation of SPAR arrangements for the management and monitoring of vulnerable prisoners, while mixed in terms of delivery represents an improvement on previous practice. In addition, the provision of dedicated resources to the management of vulnerable prisoners and the opening of the Donard Centre at Maghaberry Prison are welcome developments.

At the same time healthcare across the prison estate, particularly in Hydebank Wood Young Offenders' Centre (YOC) and Maghaberry Prisons require improvement; and progress has been undermined by the attitudes and behaviours of some staff which is inconsistent with a therapeutic approach to prisoners in their care. We endorse the objective of the NIPS Strategic Efficiency and Effectiveness (SEE) programme in its attempts to change the culture and skills of staff within the service.

The previous inspection noted that prisons were not therapeutic environments yet they had to deal with some very disturbed and dangerous individuals who were a risk to themselves and other people. This remains the case. This inspection shows that the NIPS has taken steps to address many of the concerns raised in the previous report. While all the risks can never be eliminated, the report shows that investment of effort and resources does bear results. Further progress is to be encouraged.

The inspection was carried out by Tom McGonigle of CJI and Elizabeth Colgan from the Regulation and Quality Improvement Authority (RQIA). My thanks to all those who participated in the inspection process.



Dr Michael Maguire
Chief Inspector of Criminal Justice in Northern Ireland
January 2012

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Executive Summary

CJI published a report on the NIPS management of vulnerable prisoners in December 2009. Inspectors made only ten recommendations in order to avoid restating recommendations that had previously been made elsewhere. The NIPS published an action plan a fortnight later, accepting six of the recommendations in full and four in part.

In April 2010 CJI reported again by letter to the Minister of Justice in respect of six specific concerns that were outstanding from the December 2009 inspection. These included staff double-jobbing, emergency access to cells at nights and heating levels in observation cells.

This follow-up review was conducted in August 2011 by CJI and RQIA and was scheduled to allow opportunity for the 2009 recommendations to be implemented. Inspectors conclude that, of the ten recommendations made in December 2009:

- 2 have been achieved;
- 6 have been partially achieved; and
- 2 have not been achieved.

Within a context of an overall increase of some 350 prisoners the NIPS had made good progress in some areas:

- Opening the Donard Centre for vulnerable prisoners at Maghaberry Prison was a major achievement;
- There was less usage of observation cells and anti-ligature clothing and more individualised assessment of vulnerable prisoners;
- Managerial oversight had improved and there was more robust self-audit; and
- Practical steps had been implemented to provide emergency cell access at nights and lockable in-cell cupboards.

Improvements in the wider prison environment enhanced the regime for everyone, including vulnerable prisoners:

- There was closer management of night custody staff;
- 140 prisoners had been granted "walker" status at Maghaberry Prison since May 2011. This meant they could move freely within the confines of the prison without staff escorts; and
- Collaboration with the South Eastern Health and Social Care Trust (SEHSCT) was helping to bolster safer custody provision by introducing new staff and ways of working.

Despite these improvements, inadequate governance within the NIPS continued to provide a poor context for delivery of safer custody. This included underperforming staff not being held accountable; important policy areas such as security and safer custody not cross-referring; cumbersome planning – Maghaberry Prison's business plan for 2011-12 was predicated (in August

2011) on corporate and business plans that were still only in draft form; there was very little dynamic security and no effective anti-violence strategy.

At operational level the NIPS regimes entailed too much lock-up time, insufficient education and activity, and in the case of Hydebank Wood Young Offenders' Centre and Women's Prison an underperforming healthcare department. As it is impossible to ever conclude that the SPAR process is always being properly implemented by all members of staff, the NIPS will have to continuously monitor and challenge quality of practice and recording in this area. Other areas for improvement include poor quality living environments for most vulnerable prisoners; and Inspectors again noted cynicism of some staff and distancing from prisoners, though it was encouraging that managers were more challenging of such attitudes than in the past.

The consequences of all this for prisoners were both emotional and practical. They included regularly feeling that they were not being treated with respect, boredom, delays in mail delivery, shortened visits and limited phone access. Such frustrations were significant for someone who was locked up and added to existing vulnerabilities.

These deficiencies have been widely-reported in the past. The NIPS has acknowledged them and initiated the SEE Programme in response. It was launched in June 2011 with the aim of professionally developing the role of all prison officers.

Inspectors fully endorse the aims of the SEE programme, which are of necessity far-reaching. However it carries considerable risk as it is expected to significantly reduce staff numbers. The implications of this are concerning for vulnerable prisoners and we urge that their needs should be prioritised.

Section 1

Follow-up Review

CHAPTER 1:

Introduction and context

2009 Inspection summary findings

1.1 Our main finding in December 2009 was that while the NIPS had worked hard and delivered the letter of safer custody recommendations, it still had considerable scope for progress in relation to implementing their spirit. The NIPS was better at providing safe custody for compliant prisoners than for disruptive prisoners; and their numerous procedural improvements did not translate into meaningful outcomes for vulnerable prisoners.

1.2 There were concerns about suitability of the regime in each establishment, particularly Maghaberry Prison. Activities were in too short supply and out of cell time was much less than would be expected – often due to industrial action by the Prison Officers' Association (POA). Lack of priority for Maghaberry Prison's 'Reaching out to prisoners through Engagement, Assessment, Collaborative working and Holistic approach' (REACH) landing thwarted the original concept of a dedicated landing for vulnerable prisoners.

1.3 There were some positive findings: there had been a flurry of activity around prisoner safety and management information had improved considerably. Inspectors met some excellent and committed staff who were making a difference, yet it was too often on the basis of individual interest rather than within a corporate framework. Cynical attitudes remained, there was an overriding security focus and certain staff remained reluctant to engage with prisoners. The HQ-based safer custody manager was transferred to other duties on three occasions for lengthy periods. We made specific comment about the NIPS capacity to manage inspection action plans and reminded the NIPS that many previous safer custody recommendations still required attention.

Subsequent developments

1.4 By October 2011 the context had changed as the NIPS was holding nearly 350 extra prisoners since we last inspected (1,391 prisoners on 21 December 2009 and 1,738 prisoners on 25 October 2011, a 25% increase). This placed pressure on all aspects of the system, especially at Maghaberry Prison where most prisoners were held.

1.5 The Minister of Justice continued to chair a cross-departmental forum on safer custody which was established to drive improvements and deliver a sustained reduction in self-harming by people held in custody.

1.6 There was a high prevalence of mental health problems and personality disorders amongst the prison population. The NIPS could not meet this challenge alone and relied on the Minister of Health and other partners across the justice system and in the wider community. The NIPS had been working with the SEHSCT - which assumed lead responsibility for delivery of healthcare in prisons in April 2008 - to put measures in place to assess and support prisoners. These included:

- Appointment of a clinical facilitator to develop the skills of staff who were working with vulnerable prisoners;
- Embedding the Supporting Prisoners at Risk (SPAR) process, which was designed for managing prisoners at risk of self-harm or suicide;
- Developing the Donard Centre at Maghaberry Prison to provide a therapeutic daytime regime for the most vulnerable prisoners;
- A forensic psychiatrist had been appointed. There was also a locum psychiatrist and a registrar providing cover for the three prisons; and
- On a wider front the NIPS was working with voluntary sector organisations such as NIACRO and the Samaritans to enhance prisoners' contact with their families and provide a Listener Scheme in the prisons.

1.7 Reform of prison healthcare – which fulfils a particularly important role with vulnerable prisoners – had recently gained momentum. In addition to the clinical facilitator, managerial posts had been filled including a dedicated assistant director with the SEHSCT, a lead nurse for the three prisons and an operational nurse manager in each prison. An Occupational Therapist had been appointed to Maghaberry Prison and a personality disorder nurse was being recruited at the time of this inspection.

1.8 Plans were in hand to address inefficiencies that had been identified in healthcare practice. These included:

- A new pharmacy model was due to be implemented from September 2011 with the aim of freeing up a considerable amount of nursing time, 75% of which had previously been spent on issuing medications; and
- A screening process was being developed to reduce inappropriate referrals to mental health and addictions teams, and thereby to shorten waiting times for prisoners who really needed specialist attention.

1.9 The NIPS still needed to redeploy mental health nurses away from general nursing duties and reduce over-reliance on agency staff.

1.10 Inspectors saw evidence of progress in healthcare and the work that was in hand. There were frustrations within the NIPS about slow progress by the SEHSCT in getting new staff into post and changing working practices. However, it had been difficult for the Trust to deal with entrenched problems which were ignored in the past. The NIPS will need to provide a positive context for delivery of healthcare services through the SEE programme; and collaborative working will be essential if they and the SEHSCT are to improve the care of vulnerable prisoners.

Data

1.11 Vulnerability factors in prison were well-known: 26% of self-inflicted deaths were within the first two weeks of admission to custody; 38% were remand prisoners; 51% had one or more psychiatric diagnoses; and females were proportionately at greater risk. There were an average 85 self-inflicted deaths in Her Majesty's Prison Service (HMPS) custody in England and Wales each year between 1999-2007, and analysis showed an overall significant downward trend in the 110 prisons there during that period[1]. More recent figures show this trend has continued: the HMPS rate for 2009 was 7.3 per 10,000 prisoners (61 deaths) and 6.8 per 10,000 prisoners (58 deaths) in 2010. The NIPS recent figures (2 deaths in 2010 and 3 deaths to date in 2011) represent high rates (14 and 18 per 10,000 prisoners respectively) by comparison, but it is not valid to draw statistical comparisons from numbers and populations that are so radically different in size.

1.12 The NIPS Suicide and Self Harm policy required that where a prisoner self harmed to the extent that they needed outside hospitalisation, or where they would have likely died if not for the intervention of a third party, then a review of the circumstances should be completed. Data in relation to "near misses" - which are another important indicator of how vulnerable prisoners are managed - showed that a total of 16 cases were reviewed during the period July 2010–October 2011.

1.13 The data in Tables 1 and 2 were provided from the NIPS Prison Record and Inmate System Management (PRISM) database. They indicate rates of vulnerability in each establishment and how they were being managed. These data are encouraging as they rely less on physical measures - observation cells, detention in Care and Supervision Units (CSUs) and anti-ligature clothing - than when we inspected in 2009. The NIPS suggested greater levels of managerial oversight also meant durations of detention in observation cells were generally shorter than in 2009.

1.14 Magilligan Prison had much lower levels of vulnerability than the other establishments. This was not surprising as it had a smaller population that was comprised entirely of sentenced prisoners, and it did not have an in-patient facility. The irony was that it was not used for vulnerable prisoners who might benefit from its relatively relaxed environment.

Table 1 - NIPS SPARs opened January – June 2011

	Hydebank Wood YOC	Hydebank Wood Women's Prison	Magilligan Prison	Maghaberry Prison	TOTAL
SPARs opened	100	42	18	233	393
No of prisoners	65	25	17	171	278
Average duration - days	9.1	10.45	3.83	10.08	8.4
Range - days	0 – 98	1 – 72	0 – 24	0 – 83	0 - 98

1 'A National Study of Self-Inflicted Deaths in Prison Custody in England and Wales from 1999 to 2007,' The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, University of Manchester, Departments of Health and Justice.

Table 2 - NIPS SPARs opened January – June 2011 by regime level, observation cell, CSU and anti-ligature clothing usage

	Hydebank Wood YOC	Hydebank Wood Women's Prison	Magilligan Prison	Maghaberry Prison	TOTAL
Regime Level					
Enhanced	**20**	**16**	**5**	**27**	**68**
Standard	**72**	**25**	**10**	**183**	**290**
Basic	**8**	**1**	**3**	**23**	**35**
Observation cell used					
No of Prisoners	**18**	**9**	**8**	**47**	**82**
No of Occasions	**29**	**26**	**8**	**57**	**120**
CSU used					
No of Prisoners	**4**	**0**	**4**	**12**	**20**
No of Occasions	**5**	**0**	**4**	**14**	**23**
Anti-ligature clothing used					
No of Prisoners	**11**	**2**	**1**	**28**	**42**
No of Occasions	**16**	**2**	**1**	**31**	**50**

1.15 The actual SPAR figures represent a slight increase from the 2009 data, but the *rate* had significantly reduced as there were nearly 350 additional prisoners. On 25 October 2011 the open SPAR rate was 1% (17 prisoners within a total NIPS population of 1,738) compared to the 8 September 2009 rate of 1.7%. The average duration of SPARs has increased from six days to nearly ten days. Apart from staff and managers suggesting they were applying greater levels of caution in assessing and managing vulnerability, it is difficult to draw any firm conclusions from this data.

CHAPTER 2:

Progress on Recommendations

General

2.1 Magilligan Prison, the YOC and Hydebank Wood Women's Prison have each had individual inspections since the Vulnerable Prisoners report was published in December 2009. These inspections found there had been improvements in delivery of safer custody. Summary findings are outlined below:

Magilligan (March 2010)
"Some procedural matters needed attention but outcomes for prisoners were reasonably good against this healthy prison test…. Levels of self-harm were low and few supporting prisoners at risk (SPAR) documents were opened. The SPAR process operated effectively, with multidisciplinary attendance at case conferences and care plans that took account of prisoners' identified needs."

Hydebank Wood Young Offenders' Centre (March 2011)
"We found much more substantial improvement (than in 2007)…. there were relatively few investigations into allegations of bullying, which were often not pursued when allegations were withdrawn. However, the investigations we looked at were thorough. The NIPS suicide and self-harm prevention policy did not fully reflect and differentiate the distinct and specific needs of children and young adults at the YOC. Levels of self-harm were not high and some useful investigations into serious incidents had been carried out…Supporting prisoners at risk (SPAR) procedures had improved with well-attended multidisciplinary reviews, although some care plans were not completed."

Hydebank Wood Women's Prison (March 2011)
"Although a more therapeutic approach to support women at risk of suicide or self-harm was needed, reasonable progress had been made... Levels of self-harm were not high…There was less reliance than previously on physical measures such as use of observation cells and protective clothing. Better entries in monitoring documents demonstrated some good engagement with prisoners at risk."

2.2 While safer custody had improved at the YOC - which arguably holds the most vulnerable groups of prisoners - Inspectors were concerned about particular difficulties with healthcare in March 2011, and also about risks from ligature points that required urgent remedy. It did not appear that the healthcare lead was working with the safer custody lead or others, and there was evidence that healthcare staff were not sharing appropriate information to reduce risks of suicide and self harm. There were also problems in relation to the NIPS sharing information about

serious adverse incidents with the SEHSCT. We said:

"Despite the transfer of responsibility to the South Eastern Health and Social Care Trust, health services were under-resourced, poorly managed and there was sometimes unsatisfactory attention to the needs of patients. The needs of young men and children with mental health problems were a particular concern. Mixing children, young adult men and women in the health centre made it difficult to provide an appropriate regime. First night treatment and symptomatic relief for substance-dependent young men was not sufficiently robust and we were particularly concerned that those undertaking alcohol detoxification were put at risk because they were not always admitted to the health centre. Addiction services were under-resourced."

2.3 The same concerns existed when Inspectors revisited the YOC in August 2011. We heard examples of nursing staff conduct that would not always have been in keeping with the Nursing and Midwifery Council professional code of practice. The NIPS and the SEHSCT managers were aware of these problems and told us in September 2011 that plans were well-developed to imminently address them. There had also been improvements in the YOC since the inspection in March, accelerated by the deaths of two prisoners, and near death of another on 4 May 2011:

1. A Child and Adolescent Mental Health Services (CAMHS) consultant had been appointed to provide sessions dependent on need. The consultant was undertaking preliminary assessments prior to any formalised time being arranged;
2. Nursing staff were meeting with CAHMS nurses to develop networks;
3. A clinical psychologist post had been advertised;
4. A personality disorder nurse had been offered employment but declined, so the SEHSCT was deciding whether to re-advertise or approach the Belfast Health and Social Care Trust Self Harm Team for input;
5. Two additional part-time Cognitive Behaviour Therapy (CBT) nurses had been appointed. However one - based in Magheraberry - had left;
6. A consultant psychiatrist had been appointed; and
7. Mental Health Nurses time was now ring fenced, with one RMN working in mental support for a period of three months.

2.4 Our December 2009 recommendations are set out below followed by the NIPS reaction to the recommendation. The NIPS action plan did not always contain relevant steps, but where it did these are outlined. Then we set out our August 2011 assessment of achievement with supporting evidence.

References to paragraph numbers in brackets relate to the CJI Vulnerable Prisoners Report 2009.

Recommendation

2.5 The NIPS should renew its efforts to promote violence reduction as part of its safer custody strategy in equal measure with the effort invested in suicide and self-harm (*paragraph 2.12*).
Status: Partially Accepted

Action plan response

2.6 The NIPS action plan said a Violence Reduction Survey would be completed. A Challenging Anti-Social Behaviour (CAB) scheme would be implemented by March 2010 and a corporate anti-social behaviour policy by May 2010.

CJI assessment

Not Achieved

2.7 A survey was not completed and the NIPS said that introduction of the CAB policy throughout the Service had been put on hold pending implementation of the SEE programme. At the YOC in March 2011 healthcare staff were unaware of the policy and nobody had received training in relation to bullying and violence reduction.

2.8 A Challenging Anti-Social Behaviour (CAB) programme was piloted in the women's prison. There was also a three month CAB pilot in one house at Maghaberry Prison, and staff there received training. Fourteen cases of bullying were identified, most of which were dealt with informally. Magilligan Prison had a harm reduction scheme, which was viewed as successful, instead of a CAB scheme. Prison officers at Maghaberry Prison still did not maintain a routine presence in association areas and exercise yards. This meant they were ideal environments for bullying and other nefarious practices, and therefore unattractive to vulnerable prisoners who could otherwise benefit from the social interaction opportunities in these communal areas if they were properly staffed.

2.9 A review of the CAB pilots was undertaken in March 2011. It found a trend towards counter-allegations being lodged once complaints of bullying were made. The limited data differentiated substantiated bullying from unsubstantiated complaints, and also showed significant overlaps between victims and perpetrators.

Recommendation

2.10 The NIPS should review and strengthen its capacity for more critical self-appraisal and recommendations should be followed by SMART action plans (*paragraph 3.6*).
Status: Accepted

Action plan response

2.11 The NIPS action plan said a safer custody plan would be implemented by January 2010 and a Safer Custody Programme Board operational by February 2010. The Board would present quarterly reports to the Prison Service Management Board (PSMB) from March 2010. Annual reports, business and corporate plans would report on safer custody and contain strategic workstreams. NIPS would sponsor a safer custody conference during 2010-11 and implement an "Improving Quality of Life" survey in establishments.

CJI assessment

Partially Achieved

2.12 Inspectors saw several documents that represented improvement on previous attempts at critical self-evaluation. At strategic level these included:

- The NIPS 2010-2013 business and corporate plans referred to safer

custody and set specific objectives. The 2010-2011 annual report contained 42 objectives, of which four related to safer custody. It concluded that none of the four targets or objectives were met;

- A corporate audit of compliance with 33 safer custody standards was conducted in July 2011. The resulting report awarded an overall Amber (limited assurance) rating. It concluded that the NIPS was compliant with 30.4% of standards; housekeeping was required in respect of 43.1%; and there was non-compliance in respect of 26.5%. It also assessed the NIPS was fully compliant with 40% (86) of 214 current safer custody recommendations; partially compliant with 38% (81); and non-compliant with 22% (47)[2]; and
- There were still gaps at strategic level: Prison Service Management Board minutes for the period January-July 2011 did not contain any evidence of quarterly reports being presented in relation to safer custody. An undated audit (*'Maghaberry as it now sits - Master Action Plan'*) suggested there was a plan to implement the findings of a report to minimise drugs supply, but it was unclear whether there was any reduction in supply as a result; and there was no evidence of any progress on an important recommendation that *"Staff should actively patrol communal areas."*

2.13 At operational level each establishment had made progress in developing capacity for more self-critical analysis, largely due to the efforts of the safer custody co-ordinators. Inspectors saw some of these audits. They were detailed and demonstrated good insight, making recommendations for improvements in individual cases and in the overall SPAR process:

A Maghaberry Prison safer custody audit in January 2011 concluded the prison was *"partially compliant"* and said *"The team could not find evidence to suggest that Maghaberry Prison was fully compliant with any of the recommendations which were audited……still evolving…residential staff did not have a clear vision of their role in the process…there is an expectation of safer custody to do this…"* The audit made nine recommendations for improvement; A YOC and Ash House SPAR audit in August 2011 contained detailed analysis of 178 cases undertaken by the safer custody co-ordinator. It scrutinised recording accuracy, attendance at meetings, managerial oversight, quality of observation and conversational checks, timeliness and action plans. All of this was fed back regularly to staff at safer custody fora and individually. An audit of Magilligan SPARs for the period April-June 2011 by the safer custody co-ordinator concluded *"the majority of entries and comments are of a high standard…"* It was positively endorsed by the deputy governor; and the NIPS HQ head of safer custody organised a safer custody conference which was well-attended in February 2011.

Recommendation

2.14 The NIPS should by January 2010 revise its safer custody meeting structure to clarify participation and input

2 Report from the Standards Audit and Compliance Unit into the provision of Safer Custody within the NIPS – July 2011.

expectations, differentiate between strategic and operational agendas and train staff in focusing on outcomes rather than actions (*paragraph 3.17*).
Status: Accepted

Action plan response

2.15 The NIPS action plan did not address the substance of this recommendation.

CJI assessment

Partially Achieved

2.16 Despite the action plan inadequacy and two changes of safer custody lead at the NIPS Headquarters, Inspectors saw minutes of regular meetings at HQ level that maintained a focus on strategic issues across the NIPS estate e.g. feedback in respect of SPARs quality, CAB developments, child protection and Listener trends, difficulties with information sharing and data accuracy issues. Each meeting adhered to a relevant and consistent agenda, and the forum provided useful sharing across the NIPS estate. The main area for improvement was attendance levels which were variable, with healthcare particularly poorly represented.

2.17 At the local level Maghaberry's safer custody minutes for the period January-June 2011 showed good levels of attendance with a consistent governor chairing and higher level overview of important themes such as the lack of Security Information Reports being forwarded by landing staff. Maghaberry Prison's February 2011 minutes reported *"…the audit team had reported back saying that our meetings were better than anticipated, but not as good as we should be…"*

2.18 Hydebank Wood safer custody meetings were clearly galvanised by the deaths of two prisoners there on 4 May 2011. Subsequent meetings were strategic and well attended with relevant agendas and supporting data which was analysed. The minutes evidenced considerable effort to get as many prisoners out of their cells for as long as possible, though prisoners reported this was counter-productive as there was little for them to do. Some staff would not let them use recreational facilities because these were only meant to be available in association time. They also showed engagement of awareness training for staff in dealing with bereavement.

2.19 Inspectors attended safer custody meetings at both Maghaberry Prison and the YOC. These were valuable with nearly all disciplines contributing their knowledge. However, at the YOC the lack of information sharing by healthcare personnel was again apparent, just as it had been in March 2011.

2.20 While commending good practice the NIPS corporate audit of safer custody identified that some staff were following a process without necessarily understanding it and therefore unlikely to deliver the desired outcome: *"There continues to be a dominant culture of genuine fear from managers and officers alike around the management of prisoners who are vulnerable, with staff more worried about making a mistake rather than being effective….Application of the current policy was process-driven with the emphasis on filling forms and booklets without analysing the information…In many ways staff and managers viewed this as the best way to protect themselves rather than the means whereby the best and appropriate outcome could be achieved for prisoners."*

Recommendation

2.21 The NIPS should introduce a personal officer/wing-based case manager scheme, at least on a pilot basis for prisoners who are considered by the safer custody committees (*paragraph 3.18*).
Status: Accepted

Action plan response

2.22 The NIPS action plan said personal officer scheme standards and operational guidance would be in place by April 2010. The scheme would be piloted by June 2010 and evaluated by September 2010.

CJI assessment

Partially Achieved

2.23 The standards and operational guidance had not been delivered, and the concept of a personal officer scheme was placed on hold pending the SEE programme which intends to incorporate the role of personal officer as a key function for all prison staff. Inspectors fully endorse the intention that all staff should take responsibility for suicide and self-harm and that no single discipline should be seen as in control of this process. However, previous attempts (most recently the Officer Development Programme in 2009) to do this have failed, and we are particularly concerned that vulnerable prisoners should be protected during the SEE transition.

2.24 It was encouraging that prisoners in Maghaberry's new Donard Centre had both a nominated personal officer and a backup officer. If the named officer was not on duty the senior officer fulfilled these roles. Inspectors saw minutes of case reviews where the nominated personal officer was absent and the senior officer provided NIPS' operational input. While the NIPS accepted that trained senior officers should provide continuity in case management, Inspectors were informed that with days off and annual leave it was not always possible for a trained senior officer to provide continuity in the management of cases. In healthcare a system similar to the personal officer scheme (the "keyworker" system which is similar to the "named nurse" principle) was in operation at Maghaberry Prison and Hydebank Wood.

Recommendation

2.25 The Maghaberry Prison governor should undertake a review of the current arrangements for staff allocation in consultation with the POA in order to deliver a more flexible approach to resource allocation that will help deliver an improved regime for vulnerable prisoners (*paragraph 3.28*).
Status: Partially accepted

Action plan response

2.26 The NIPS action plan did not address the substance of this recommendation.

CJI assessment

Achieved

2.27 Although the NIPS action plan did not address the substance of this recommendation, restructuring at Maghaberry Prison had led to creation of a Prisoner Safety & Support Directorate as one of five functional

areas within the prison. A governor 5 had specific responsibility for safer custody at Maghaberry Prison; and three principal officers, a senior officer and 14 officers were dedicated to the new Directorate. Their role was to staff the new Donard Centre and the residential area where vulnerable prisoners lived. This was a generous staffing allowance that provided consistency across residential and daytime environments.

2.28 When developing the Donard Centre programme the NIPS invited expressions of interest from prison officers who wanted to work there. Those who were appointed each received ten days external training in March/April 2011, organised by the clinical facilitator. Their training included patient-centred care, personal officer responsibilities, therapeutic management of challenging behaviour, skills in de-escalation, record keeping, challenges for prisoners with a learning disability, personality disorders overview and mental health awareness.

2.29 The Donard Centre prison officers had good insight into its ethos and programme and most were well-motivated. In order to provide further support there were plans for a cognitive behaviour nurse therapist to commence support sessions. The officers had individual development plans and all were scheduled to have annual appraisals.

2.30 In addition to the prison officers the Donard Centre also had two other SEHSCT personnel – the clinical facilitator and an Occupational Therapist.

Recommendation

2.31 The NIPS should prioritise implementation of the REACH proposal that was devised with the South Eastern Health and Social Care Trust (SEHSCT) in April 2009 (*paragraph 3.31*).
Status: Accepted

Action plan response

2.32 Clear line management of REACH would be in place by December 2009; additional SEHSCT staff would be in post by September 2010; and a therapeutic environment would be created by September 2010.

CJI assessment

Achieved

2.33 There was a period of considerable difficulties on the former REACH landing during 2010, which included allegations of prisoners being bullied by staff. These were ultimately not proven, but highlighted even more the need for a properly-designed and staffed regime for Maghaberry Prison's vulnerable prisoners.

2.34 Although timescales were not achieved, the new Donard Centre opened in July 2011. Its aim was to help vulnerable prisoners live safely within the prison environment, reduce self-harming behaviour and stabilise their mental health. The Donard Centre was a purpose-built facility which took up to 19 of the most vulnerable prisoners every weekday. While other prisoners were locked in their cells over lunchtime, the Donard Centre prisoners remained in the Centre. The environment was pleasant and apart

from uniformed staff, there were few prison trappings in evidence.

2.35 Criteria for entering and leaving the Donard Centre programme had not yet been developed. However it was positive that prisoners could self-refer and the entry/exit process was clearer than in the past: it was managed by the Prisoner Safety and Support Group, chaired by the relevant governor. Applicants who were not accepted received a written explanation along with advice to staff for managing the prisoner in their normal location.

2.36 Inspectors observed planning discussions that considered needs of the wider group as well as needs of individual prisoners. Weekly multidisciplinary review meetings were held for each prisoner, and the philosophy was that prisoners should return to their normal location as soon as possible. Discharge plans and relapse prevention strategies were devised and follow-up reviews scheduled. The Donard Centre activities programme included craft sessions, gardening, cooking, music, literacy, maths, art, cognitive behaviour sessions, stress management, acupuncture, spirituality and library time.

2.37 Inspectors spoke with most of the prisoners in the Donard Centre. The atmosphere was relaxed, and their feedback was positive. Vulnerable prisoners particularly valued their regular access to the gardens, on up to seven days per week. This was not happening when we last inspected. Another positive development had been the increase in prisoners' family members being invited into the prison to participate in case conferences. Prisoners told us they appreciated this, and staff had been surprised at how much they actually learned about the prisoner from family members.

2.38 The next step should be to improve vulnerable prisoners' residential living arrangements – they still returned each evening to poor quality residential accommodation in Foyle House. However, it was encouraging that the Donard Centre staff also worked on this landing, which provided consistency and assisted relationship building.

2.39 In another significant development at Maghaberry Prison, 15 prisoners deemed to be at risk from others (though not self-harmers) were moved out of Glenn House when a female prisoner was located there in May 2011. They were relocated to Foyle House, where they were unhappy as they were subject to verbal abuse and threats from an adjacent landing, though they acknowledged *"staff try hard."*

2.40 There was still no day care provision at the YOC. A joint NIPS/SEHSCT review of options for the transfer of therapeutic and occupational activities from the Donard Centre to the YOC was ongoing at the time of this inspection. Given the vulnerabilities of the YOC's prisoner populations this process should be treated as a priority.

2.41 Inspectors spoke with prisoners who had current or recent open SPARs at each prison. Their feedback was more positive than when we last inspected. Some felt that placement in an observation cell was a punishment. However, they reported that usage of observation cells was more individualised now than in the past e.g. a prisoner who had recently been in an

observation cell told us he was placed there briefly to calm down while his cell was searched. Monitoring of observation cell usage was available from PRISM which could provide detailed records of prisoners' entry to, and exit from observation cells.

2.42 Those who had been in observation cells said the duration was usually short and staff spoke regularly with them, on occasions leaving the door ajar so that they would not feel cut off. The prisoners outlined a range of activities to occupy their time, and most recognised that staff were trying to assist.

Recommendation

2.43 The NIPS should redefine its activity categories to more accurately distinguish constructive activities from routine aspects of prison life (*paragraph 4.15*).
Status: Accepted

Action plan response

2.44 It would be a "high priority" for the NIPS to provide more out of cell time; and
A review would be conducted and baselines set to increase out of cell time by May 2010.

CJI assessment

Not Achieved

2.45 Activity categories had not been redefined by August 2011. The NIPS efforts to provide sufficient activity for its population had become more difficult as the population increased. One of the factors identified in the apparently self-inflicted death of a young man at the YOC in August 2010 was that he did not have sufficient time out of his cell.

2.46 After the two prisoner deaths on 4 May 2011 the YOC placed particular emphasis on getting prisoners out of their cells. Safer custody meetings in June 2011referred to *"Instruction to staff in regard to there being no routine lockups and to measures that have been introduced to maximise time out of cell."* However this was proving difficult to sustain and by August 2011 minutes showed that staff felt under considerable pressure with the numbers of prisoners unlocked. PRISM data did not show any significant or sustained increase in prisoners' time out of cell at the YOC, though Prison Service Management Board minutes in July 2011 suggested central detailing was leading to prisoners having more time out of cell. Inspectors were told in August 2011 that the recent traumatic incidents had led to the YOC staff placing young people on SPARs very quickly. It was also apparent that SPARs could be closed quickly, though this was safeguarded by the process requiring closure to be agreed by an interagency meeting rather than by a sole practitioner.

2.47 The undated *'Maghaberry Prison as it now sits - Master Action Plan'* also outlined an aspiration to increase time out of cell. The outcome was unclear but the plan suggested *"The establishment can't meet the current core day"* as measured daily via PRISM updates. Various reports including CJIs inspection of NIPS Corporate Governance and the recently published Prison Review Team findings have highlighted how the regime for prisoners could be improved if staff working practices were amended.

2.48 Magilligan Prison estimated that prisoners held in it's H Blocks averaged 10 hours per day out of their cells, while those in more relaxed areas such as Alpha and Foyleview averaged 16 hours per day out of cell. Prisoners there told Inspectors that while they had comparatively lengthy periods out of cell, there was insufficient activity to fully occupy them.

Recommendation

2.49 Maghaberry Prison should establish a prisoner forum (*paragraph 4.19*).
Status: Accepted

Action plan response

2.50 The NIPS action plan said that a forum would be established, with safer custody a standing item on the agenda.

CJI assessment

Partially Achieved

2.51 Inspectors saw 23 sets of minutes of prisoner fora covering the period November 2010-July 2011. Rather than a forum for the entire prison, fora at Maghaberry and Magilligan Prisons were organised on an individual house basis, or for specific groups such as foreign national and disabled prisoners. There was no evidence that the meetings were routine, that safer custody was discussed, or that there was a standard agenda. However regime deficiency issues that contributed to vulnerability - e.g. lengthy lockups, collective punishment, delays in processing mail and truncated visits - were tabled.

2.52 Minutes indicated that the fora ranged widely in quality of chairing and the NIPS engagement with the issues raised: some were very interactive while others were simply one way lectures by prison staff. It was positive that the process had at least commenced. The fora should now develop to become a more serious process of regular and meaningful engagement.

Recommendation

2.53 The NIPS should set targets for increasing the numbers of Listeners in each establishment and produce an action plan to improve their deployment (*paragraph 4.22*).
Status: Partially Accepted

Action plan response

2.54 The NIPS action plan said Maghaberry Prison recognised the need for at least 12 Listeners; and that the NIPS HQ would develop standard operating procedures for Listeners by April 2010.

CJI assessment

Partially Achieved

2.55 Service Level Agreements with the Samaritans had been put in place in March 2010 for each prison establishment. A policy for the operation of Listeners across the Service had been drafted, but was deliberately held back due to the ongoing difficulty in recruiting and retaining Listeners at the YOC. Discussions with the Samaritans continued regarding funding for their services.

2.56 PRISM data showed an average 36 Listener callouts per month at Maghaberry and Magilligan Prisons; though this was recognised as an

underestimate because it was based on out-of-house movements which did not count Listeners used within their own house.

2.57 Attempts to establish a Listener scheme at the YOC were unsuccessful due to the rapid turnover of prisoners and prisoners' concerns about confidentiality. Young prisoners were able to contact the Samaritans free of charge from landing telephones. They were provided with a universal PIN to use the public phone on the landings or a Bluetooth earpiece if they wanted to phone the Samaritans from their cells.

2.58 The Listener scheme for female prisoners at Hydebank Wood was continuing, though struggled with similar issues of confidentiality and mistrust among the small number of prisoners held there.

2.59 Maghaberry Prison had worked hard to increase the number of Listeners, but in August 2011 it was down to six, even though the formerly obstructive security department was now trying to assist. The last recruitment round had yielded 27 nominees, but many were high profile, sex offenders, paramilitaries or drug dealers - the prison had difficulty in allowing free access by these prisoners. A more liberal approach was tried (e.g. holding off on adverse reports) but managers reported it was quickly flouted by prisoners; and when the scheme was extended to remandees, most were lost at an early stage due to being granted bail or discharged at court.

2.60 Magilligan Prison had eleven Listeners on its rota. Inspectors heard from some of them and from staff that the scheme there was working well.

Recommendation

2.61 The NIPS should provide guidance on basic file recording for its staff who interact with prisoners; and follow this up with an audit to measure improvements (*paragraph 4.25*).
Status: Partially Accepted

Action plan response

2.62 The NIPS action plan said SPAR would be fully implemented by March 2010 and evaluated by January 2011.

CJI assessment

Partially Achieved

2.63 Guidance on basic file recording had not been issued and agency nurses told Inspectors they were totally unfamiliar with recording requirements. Healthcare staff at Maghaberry Prison were in possession of the pilot anti-bullying documentation but unaware of its origins and had not received any training in either the policy or associated documentation. That said, the SPAR process had been fully operational since December 2009 and it was useful in guiding staff through the recording process. Prisoner feedback and documentation provided evidence that prisoners were involved in their care planning and SPAR process; and several audits had assessed the quality of file recording. The NIPS was more alert to the importance of proper recording to reflect work undertaken than when we last inspected.

2.64 A January 2011 internal audit at Maghaberry Prison found the NIPS was partially compliant with the requirement to carry out and record observations of

vulnerable prisoners; and a February 2011 audit reported *"…application of new SPAR procedures is not consistent…Entries are good during the day…Flaws on recording 15 minute watches – not acceptable…More description required on SPAR forms…"*

2.65 Inspectors examined a small number of open and recently-closed SPAR forms. These were of mixed quality. They included minutes of case conferences and care plans. Problems and action steps were identified and frequency of conversation and observation checks were clearly documented during day time hours; night time entries were less informative. In some instances the designations of staff had not been entered. The same type of issues applied to inpatient notes and care plans – some had detailed and meaningful entries while others were poor, especially at the YOC.

2.66 There were systems in place for senior officers to check the quality of recording in SPAR documents, but in reality this responsibility usually fell to the safer custody managers. They received all completed SPAR documentation, then audited them and provided written feedback to officers with recommendations for improvement. It would be sensible to develop and implement a single standardised tool for auditing SPARs across the prison estate.

2.67 The NIPS corporate safer custody audit made a range of findings about recording. It found the cell sharing risk assessment process was generally poorly applied and understood at operational level; appropriate levels of authorisation for use of the observation cell were not always evident; there was evidence of inadequate verbal and written handovers, PRISM recording and SPAR logs. It assessed that *"Managerial checks of written records were generally poor….functional in nature…no evidence that poor entries were actually challenged…In many instances managers did not fully realise their responsibilities in this area."* These findings resonate with those of the Prison Review Team who were *"not reassured that SPAR procedures were properly implemented or the causes of vulnerability understood and engaged with."*[3]

3 Review of the Northern Ireland Prison Service, Prison Review Team Final Report, October 2011.

CHAPTER 3:

Progress on Recommendations that were *Not Achieved* or *Partially Achieved* in December 2009

3.1 In December 2009 Inspectors assessed achievement of recommendations that had been made by the Prisoner Ombudsman following the death of Colin Bell. At that stage Inspectors concluded:

- 21 were Achieved;
- 16 were Partially Achieved; and
- 6 were Not Achieved.

3.2 By April 2010 Inspectors concluded that, with the exception of double-jobbing the outstanding issues that had not been achieved in December 2009 - a Service Level Agreement with the Samaritans, heat in observation cells, emergency cell access and progress in introducing the SPAR process - had been satisfactorily progressed. It is impossible to ever conclude that such matters are always being properly implemented by all members of staff, and the NIPS will have to continuously monitor and challenge quality of practice and recording in relation to the SPAR process.

Double-jobbing

3.3 Double-jobbing was a concern because some staff were using NIPS time to rest when they were tired from other jobs. This was clearly an untenable and embarrassing position, all the more so as Night Custody Officers (NCOs) told Inspectors their positions were initially advertised as suitable for secondary employment.

3.4 When Inspectors reported on the issue in April 2010 the NIPS had yet to confirm what course of action was to be taken in respect of individuals who declared they had secondary employment, and also in respect of the high number of non-responses to a survey that was intended to quantify the problem. Corporate guidance had not been issued to establishments. A policy was at the draft stage but there had been no engagement with the trade unions. There were variations in practice, and individual establishments were taking action in the absence of corporate guidance with obvious potential to cause confusion and inconsistency, as well as risking legal challenge.

3.5 At the time of this follow-up review in August 2011 there had been no apparent progress in relation to a secondary employment policy. Table 3 was provided by the NIPS HQ in August 2011. It shows an overall 93% of staff now declaring no second job (improvement on 71% making such a declaration in April 2010, and 23% returns outstanding). In the absence of a policy the NIPS said it applied standard

Table 3 NIPS staff Double Jobbing – position at 5 October 2010

Establishment	No of staff in establishment	No / % of staff declaring no secondary employment	No / % of staff declaring second job
Maghaberry	1008	943 – 93%	65 – 7%
Hydebank	388	356 – 91%	32 – 9%
Magilligan	510	490 – 96%	20 – 4%
PECCS	193	166 – 86%	27 – 14%
HQ (inc PSC)	47	41 – 87%	6 – 13%
TOTAL	2146	1996 – 93.01%	150 – 6.98%

guidance that was contained in the Northern Ireland Civil Service Code. However this did not address the issues they faced and it is critical that proper arrangements are in place to avoid similar difficulties in the future.

3.6 In August 2011 Inspectors revisited recommendations that were "Partially Achieved" in 2009. Several of these issues are already addressed elsewhere in this report. Our findings in respect of the remaining matters are as follows:

Ensure all staff are aware of observation cells policy

3.7 At the YOC in March 2011 Inspectors found the numbers of young people placed in observation cells in healthcare and the CSU were monitored, but not the length of time they spent in these units - which was a recommendation of a previous inspection report. Inspectors also found that alternative therapeutic responses to the use of observation rooms and strip clothing had not been developed.

3.8 In one instance a young person at risk had been placed in the CSU with no recorded evidence that any alternative had been considered. There was however evidence that managers took immediate action when this came to their attention. There were other staff, such as clergy who would be willing to intervene and try to help settle prisoners without recourse to the CSU, but they were not always asked or available.

3.9 A Maghaberry Prison audit in July 2011 reported that all prisoners held in the CSU had daily reading and writing materials and radios, some had televisions, and none lost phone or tobacco privileges. It was evident from journals and prisoner feedback that there was interaction between prisoners in cellular confinement and staff. The duty governor and healthcare staff visited the CSU daily. CSU staffing arrangements had changed for the better since we last inspected as it was now manned by regular staff rather than by security personnel.

Checks on vulnerable prisoners should be unpredictable and individualised

3.10 Audits showed that the unpredictability of checks was better during the day than at night. A January 2011 Maghaberry

Prison audit found the frequency of checks was subject to individual risk assessment though in relation to unpredictable checks it found Maghaberry Prison was "*Non compliant - the audit of SPAR booklets revealed that checks were rarely carried out at irregular and unpredictable intervals.*"

3.11 The same audit reported that Maghaberry Prison was *"Partially Compliant"* with the requirement for conversational checks: NCOs were unaware of the need for these at night; checks may have been good but were poorly recorded; there were pockets of good practice; guidance had not reached staff at lower levels; and there was evidence of inappropriate comments that were not challenged.

3.12 The YOC's SPAR audits showed ongoing deficiencies *"continued in regard to completing frequency in observations and conversational checks. Noting that training had been received, the governor found this inexcusable."*

3.13 These audits also revealed 99% compliance with the requirement for staff observations to be *"sufficient and recorded,"* but only 21% of checks were conversational, and only 5% of body checks were at variable times.

Removal of televisions from Pods

3.14 Inspectors did not see any televisions in Pods. Managers informed us two televisions had been discovered since 2009, neither in a residential location, and both were immediately removed.

3.15 The NIPS did not have a CCTV policy, only a (2009) draft. As with double-jobbing they again relied upon the Northern Ireland Civil Service Code of Conduct. This was inadequate as it did not address the specifics of the problems they had in this area about the appropriateness of using CCTV footage to monitor staff conduct.

Night breaks and training for NCOs

3.16 NCOs confirmed their working arrangements had changed so that they rotated within houses during the night, and between houses on a nightly basis. This was verified by log books which were countersigned by senior officers.

3.17 NCOs at Maghaberry Prison also confirmed they had training in Applied Suicide Intervention Skills (ASIST), and that communication with managers had improved. The personnel governor was meeting them regularly and conducting night checks. One told us *"There have been significant changes over the past two years."*

3.18 Minutes of the NIPS Safer Custody Steering Group in January 2011 recorded that 50% of prison staff had received ASIST training; and at Hydebank Wood in March 2011 Inspectors noted that 55% of prison staff there had received ASIST training.

Adequacy of management access for night checks

3.19 The Maghaberry Prison July 2011 audit reported there was now a procedure in place for managers to draw master keys to improve their access to conduct night checks. However the procedure would not work if the control room had override locks enabled. It was further thwarted by the facts that front gate staff could notify others of a manager's

arrival, and the entrance doors of houses were still under camera cover.

Participation in, and attendance at cold debriefs

3.20 There had been two cold debriefs that dealt with three deaths in custody since the last inspection. It was not clear from the minutes if all relevant representatives were present, specifically from the Emergency Control Room as was previously recommended. One was not chaired by the local governor, but instead by a NIPS HQ representative. Another was completed after the maximum timescale of 14 days had elapsed. Other fora - such as the NCO Forum - were used to give staff an opportunity to express their feelings after deaths in custody.

Maghaberry Prison's governor should deliver all Suicide and Self Harm policy responsibilities

3.21 Additional physical measures which had been implemented since December 2009 to reduce risks to vulnerable prisoners included:

- NCOs now had immediate access to a sealed pouch containing cell keys to enter prisoners' cells in the event of an emergency. This was supported by the availability of a radio to contact the Emergency Control Room in the event of an incident involving a prisoner;
- Lockable cupboards were provided in most cells;
- Ligature risk assessments had been completed in some areas and new ligature-proof beds were being sourced at the time of inspection;
- Extra safer cells had been constructed; and
- Three additional observation cells had been provided in the newly-refurbished Bann House at Maghaberry Prison. However two of these were out of commission due to damage by prisoners. Prisoners confirmed that observation cells were sufficiently warm, and that they were offered appropriate clothing and slippers if required while in the observation cells.

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