Criminal Justice Inspection
Northern Ireland
a better justice system for all

Freedom of Information Officer,
Criminal Justice Inspection Northern Ireland,
Block 1, Knockview Buildings,
Stormont Estate
Belfast
BT4 3SJ.

04 May 2022

[redacted]

Our reference: FOI 0704022/047

Dear [redacted],

Thank you for your recent Freedom of Information request submitted via email to Criminal Justice Inspection Northern Ireland (CJI) on 7 April 2022.

Our understanding of the information you have requested is in two parts and is as follows:

Part 1:

- minutes and agendas of all meetings held between CJINI officials and NIPS officials from 15 October 2021 and 31 January 2022 which related to CJINI's review of the CSU; and
- minutes and agendas of all meetings held between CJINI officials and the DoJ Minister from 15 October 2021 and 31 January 2022 which related to CJINI's review of the CSU.
- You have also requested we provide all further documentation which was discussed at or relevant to these meetings.

Part 2:

- To provide copies of all correspondence (emails, letters etc) between CJINI officials and NIPS officials from 15 October 2021 and 31 January 2022 which related to CJINI's review of CSU; and
- To provide copies of all correspondence (emails, letters etc.) between CJINI officials and the DoJ Minister from 15 October 2021 and 31 January 2022 which related to CJINI's review of CSU.

To enable us to progress both Parts 1 and 2 of your request and provide the information that you request, we have interpreted your term 'CJINI Officials' as meaning the Chief Inspector of Criminal Justice in Northern Ireland, Deputy Chief Inspector of Criminal Justice in Northern Ireland and Chief Executive, CJI Inspectors involved in the

review into the operation of Care and Supervision Units (CSUs) in the Northern Ireland Prison Service and the Business and Communication Manager. If this is not correct please let us know.

We have also interpreted your term 'NIPS officials' as meaning any member of NIPS staff. If this is not correct, please let us know.

Our interpretation of your term DoJ Minister we have also taken to include the DoJ Minister's Office as well as the DoJ Minister. Again if this in interpretation is not correct, please let us know.

I can confirm the following information is being released in response to your request.

Part 1

A)

One meeting was held between CJI officials and NIPS officials from 15 October 2021 and 31 January 2022 which related to CJI's review of CSU. This meeting was held on 04 November 2021. CJI does not hold a record of an agenda or minute of this meeting, therefore no copies can be provided in response to your enquiry.

B)

One meeting was held between CJI officials and the DoJ Minister from 15 October 2021 and 31 January 2022 which related to CJI's review of CSU. This meeting was held on 19 October 2021. CJI does not hold a record of an agenda or minute of this meeting, therefore no copies can be provided in response to your enquiry.

C)

A copy of the draft review report of the operation of CSUs by the Northern Ireland Prison Service provided by CJI to the Northern Ireland Prison Service for Factual Accuracy Check was relevant to these meetings. A copy of this document is released as part of this response.

Part 2

Please find enclosed:

A)

PDF copies of all correspondence (emails, letters etc.) between CJI officials and NIPS officials from 15 October 2021 and 31 January 2022 which related to CJI's review of CSUs; and

B)

PDF copies of all correspondence (emails, letters etc.) between CJI officials and the DoJ Minister from 15 October 2021 and 31 January 2022 which related to CJI's review of CSUs which are being released in relation to this part of your request.

Two documents provided by the NIPS to CJI as attachments as part of its factual accuracy response have not been released as CJI is not the holder of this information. You may however wish to contact NIPS as the data holder in relation to this.

Information which may lead to the identification of individuals has been redacted in accordance with the General Data Protection Regulation (GDPR) except where it refers

to holders of senior public appointments or public office where the identity of the individual is already publicly known.

I hope this information satisfied your request. If you have any queries about this response, please come back to me. Should this response not satisfy your request, please contact in the first instance CJI's Freedom of Information Officer.

Their address is Freedom of Information Officer, Criminal Justice Inspection Northern Ireland, Block 1 Knockview Buildings, Stormont Estate, Belfast, BT4 3SJ or email info@cjini.org.

James Corrigan
Chief Executive
Criminal Justice Inspection Northern Ireland

Enc

- PDF 1 Scanned correspondence CJI & DoJ Minister 15.10.21 - 31.01.22;
- PDF 2 Scanned correspondence CJI & NIPS Officials 15.10.21 -31.01.22;
- PDF 3 Copy of draft report supplied with FAC request - 15.10.21;
- PDF 4 Factual Accuracy Comment Sheet - provided with report - 15.10.21;
- PDF 5 CJI Template Response to FAC comments - 21.12.21;
- PDF 6 Correspondence PR 15.10.21 - 31.01.22;
- PDF 7 CSU Report Draft 8 27.01.22 - Design draft without accessibility tagging; and
- PDF 8 CJI - CSU Report - FINAL - Tagged - 27.01.22

McVeigh, Meloney

From: McVeigh, Meloney
Sent: 04 January 2022 16:45
To: DOJ Minister's Office
Cc: [redacted] Durkin, Jacqui; [redacted] May, Peter
Subject: Submission of CJI Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service
Attachments: Version for Minister.pdf; Letter for P2P CSU Review 04.01.22.docx.pdf

Importance: High

Tracking:

Recipient	Delivery	Read
DOJ Minister's Office	Delivered: 04/01/2022 16:45	Read: 04/01/2022 16:54
[redacted]	Delivered: 04/01/2022 16:45	
[redacted]	Delivered: 04/01/2022 16:45	Read: 04/01/2022 16:59
Durkin, Jacqui	Delivered: 04/01/2022 16:45	
[redacted]	Delivered: 04/01/2022 16:45	
[redacted]	Delivered: 04/01/2022 16:45	
May, Peter	Delivered: 04/01/2022 16:45	Read: 04/01/2022 16:46
Wilson, Stevie		
Corrigan, James		Read: 04/01/2022 16:50
stevie.wilson@cjini.org	Delivered: 04/01/2022 16:45	
james.corrigan@cjini.org	Delivered: 04/01/2022 16:45	

Good afternoon,

Please find attached a copy of the CJI Inspection Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service and an accompanying letter from Jacqui Durkin, Chief Inspector of Criminal Justice in Northern Ireland, which is submitted to the Minister of Justice with a request for her permission to publish the review report.

I would be grateful if you could confirm receipt of the report and accompanying letter at your earliest convenience. Should the Minister have any queries or questions, please do not hesitate to contact the Chief Inspector or myself directly.

Both the letter and report are copied to Peter May, Permanent Secretary, Department of Justice.

Thank you for your prompt attention and Happy New Year.

Kind regards,
Meloney

Meloney McVeigh
Business and Communications Manager

Criminal Justice Inspection Northern Ireland
Block 1, Knockview Buildings,
Stormont Estate, Belfast, BT4 3SJ

Tel: 02890 765742 (Direct Line) or x 89742

02890 765764 (Switch Board)
Mobile: 0772 5581835
E-mail: Meloney.McVeigh@cjini.org

You can follow CJI on Twitter @CJININews and the CJI YouTube channel.

McVeigh, Meloney

From: [redacted]
Sent: 04 January 2022 17:06
To: McVeigh, Meloney
Cc: [redacted] Durkin, Jacqui; [redacted] May, Peter; DOJ Minister's Office
Subject: RE: Submission of CJI Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service

Meloney,

Thanks for your e-mail and attachments. I can confirm safe receipt.

I note your request for permission to publish the report – we will provide a response from the Minister as soon as we can.

Regards

[redacted] Secretary to Naomi Long, MLA
Minister of Justice
Department of Justice
Level 5| Block B, Castle Buildings| Stormont | Belfast | BT4 3SS
[redacted]@justice-ni.gov.uk

(currently working remotely – [redacted])

Department of Justice
An Roinn Dlí agus Cirt
Mànnystrie O tha Laa
www.justice-ni.gov.uk

From: McVeigh, Meloney <meloney.mcveigh@cjini.org>
Sent: 04 January 2022 16:45
To: DOJ Minister's Office <DOJ.MinistersOffice@justice-ni.gov.uk>
Cc: [redacted] <[redacted]@justice-ni.gov.uk>; [redacted] <[redacted]@justice-ni.gov.uk>; Durkin, Jacqui <Jacqui.Durkin@cjini.org>; [redacted] <[redacted]@cjini.org>; [redacted] <[redacted]@justice-ni.gov.uk>; May, Peter <peter.may@justice-ni.gov.uk>
Subject: Submission of CJI Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service
Importance: High

Good afternoon,

Please find attached a copy of the CJI Inspection Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service and an accompanying letter from Jacqui Durkin, Chief Inspector of Criminal Justice in Northern Ireland, which is submitted to the Minister of Justice with a request for her permission to publish the review report.

I would be grateful if you could confirm receipt of the report and accompanying letter at your earliest convenience. Should the Minister have any queries or questions, please do not hesitate to contact the Chief Inspector or myself directly.

Both the letter and report are copied to Peter May, Permanent Secretary, Department of Justice.

Thank you for your prompt attention and Happy New Year.

Kind regards,
Meloney

Meloney McVeigh
Business and Communications Manager

Criminal Justice Inspection Northern Ireland
Block 1, Knockview Buildings,
Stormont Estate, Belfast, BT4 3SJ

Tel: 02890 765742 (Direct Line) or x 89742
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Mobile: 0772 5581835
E-mail: Meloney.McVeigh@cjini.org

You can follow CJI on Twitter @CJININews **and the** CJI YouTube channel.

McVeigh, Meloney

From: DOJ Minister's Office
Sent: 04 January 2022 16:56
To: McVeigh, Meloney
Cc: DOJ Minister's Office
Subject: RE: Submission of CJI Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service

Please accept this as confirmation receipt from DoJ Private Office.

From: McVeigh, Meloney
Sent: 04 January 2022 16:45
To: DOJ Minister's Office <DOJ.MinistersOffice@justice-ni.gov.uk>
Cc: [redacted]<[redacted]@justice-ni.gov.uk>; [redacted]<[redacted]@justice-ni.gov.uk>; Durkin, Jacqui <Jacqui.Durkin@cjini.org>; [redacted]<[redacted]@cjini.org>; [redacted]<[redacted]@justice-ni.gov.uk>; May, Peter <peter.may@justice-ni.gov.uk>
Subject: Submission of CJI Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service
Importance: High

Good afternoon,

Please find attached a copy of the CJI Inspection Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service and an accompanying letter from Jacqui Durkin, Chief Inspector of Criminal Justice in Northern Ireland, which is submitted to the Minister of Justice with a request for her permission to publish the review report.

I would be grateful if you could confirm receipt of the report and accompanying letter at your earliest convenience. Should the Minister have any queries or questions, please do not hesitate to contact the Chief Inspector or myself directly.

Both the letter and report are copied to Peter May, Permanent Secretary, Department of Justice.

Thank you for your prompt attention and Happy New Year.

Kind regards,
Meloney

Meloney McVeigh
Business and Communications Manager

Criminal Justice Inspection Northern Ireland
Block 1, Knockview Buildings,
Stormont Estate, Belfast, BT4 3SJ

Tel: 02890 765742 (Direct Line) or x 89742
02890 765764 (Switch Board)
Mobile: 0772 5581835
E-mail: Meloney.McVeigh@cjini.org

You can follow CJI on Twitter @CJININews and the CJI YouTube channel.

McVeigh, Meloney

From: DOJ Minister's Office
Sent: 19 January 2022 15:55
To: McVeigh, Meloney; [redacted]
Subject: Criminal Justice Inspection Northern Ireland report on A Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service
Attachments: Letter to Jacqui Durkin from Minister Long - CORR-0006-2022.pdf

Good afternoon

Please see attached letter from Naomi Long MLA, Minister of Justice for the attention of Ms Jacqui Durkin.

Regards

DoJ Minister's Office

McVeigh, Meloney

From: McVeigh, Meloney
Sent: 20 January 2022 13:06
To: DOJ Minister's Office
Cc: [redacted] May, Peter; Ronnie.Armour@justice-ni.gov.uk; [redacted] Durkin, Jacqui; [redacted]@justice-ni.gov.uk
Subject: Letter to Minister of Justice from J Durkin re Care and Supervision Review Report
Attachments: Letter to MoJ re CSU 20.01.22.pdf

Importance: High

Tracking:

Recipient	Delivery	Read
DOJ Minister's Office	Delivered: 20/01/2022 13:07	Read: 20/01/2022 13:26
[redacted]	Delivered: 20/01/2022 13:07	Read: 20/01/2022 13:07
[redacted]	Delivered: 20/01/2022 13:07	Read: 20/01/2022 13:20
May, Peter	Delivered: 20/01/2022 13:07	Read: 20/01/2022 13:07
Ronnie.Armour@justice-ni.gov.uk	Delivered: 20/01/2022 13:07	
[redacted]		
[redacted]	Delivered: 20/01/2022 13:07	
Durkin, Jacqui	Delivered: 20/01/2022 13:07	Read: 20/01/2022 13:14
[redacted]	Delivered: 20/01/2022 13:07	Read: 20/01/2022 13:08
[redacted]@justice-ni.gov.uk	Delivered: 20/01/2022 13:07	
[redacted]		Read: 20/01/2022 13:07
Armour, Ronnie		Read: 20/01/2022 13:08

Good afternoon,

Please find attached a letter from Jacqui Durkin, Chief Inspector of Criminal Justice in Northern Ireland for the attention of the Minister of Justice regarding an amendment to an operational recommendation within the Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service (Review report).

I would be grateful if the content of this letter could be brought to the Minister's attention at the earliest opportunity its receipt confirmed at your convenience.

Should the Minister have any queries or questions, please do not hesitate to contact the Chief Inspector or myself directly.

Thank you for your prompt attention.

Kind regards,
Meloney

Meloney McVeigh
Business and Communications Manager

Criminal Justice Inspection Northern Ireland
Block 1, Knockview Buildings,

Stormont Estate, Belfast, BT4 3SJ

Tel: 02890 765742 (Direct Line) or x 89742
02890 765764 (Switch Board)
Mobile: 0772 5581835
E-mail: Meloney.McVeigh@cjini.org

You can follow CJI on Twitter @CJININews and the CJI YouTube channel.

McVeigh, Meloney

From: McVeigh, Meloney
Sent: 20 January 2022 18:19
To: [redacted]
Cc: [redacted] Durkin, Jacqui; [redacted]
Subject: RE: Letter to Minister of Justice from J Durkin re Care and Supervision Review Report

Thanks [redacted] greatly appreciated.

Meloney

From: [redacted]<[redacted]@justice-ni.gov.uk>
Sent: 20 January 2022 17:48
To: McVeigh, Meloney <meloney.mcveigh@cjini.org>
Cc: [redacted] <[redacted]@cjini.org>; Durkin, Jacqui <Jacqui.Durkin@cjini.org>; [redacted] <[redacted]@justice-ni.gov.uk>
Subject: RE: Letter to Minister of Justice from J Durkin re Care and Supervision Review Report

Meloney,

Sorry for not responding earlier – I can confirm safe receipt of this correspondence which has been passed to the Minister for her consideration.

[redacted] Secretary to Naomi Long, MLA
Minister of Justice
Department of Justice
Level 5| Block B, Castle Buildings| Stormont | Belfast | BT4 3SS
[redacted]@justice-ni.gov.uk

(currently working remotely – [redacted]

Department of Justice
An Roinn Dlí agus Cirt
Männystrie O tha Laa
www.justice-ni.gov.uk

From: McVeigh, Meloney <meloney.mcveigh@cjini.org>
Sent: 20 January 2022 13:06
To: DOJ Minister's Office <DOJ.MinistersOffice@justice-ni.gov.uk>
Cc: [redacted]@justice-ni.gov.uk>; [redacted]@justice-ni.gov.uk>; May, Peter <peter.may@justice-ni.gov.uk>; Armour, Ronnie <Ronnie.Armour@justice-ni.gov.uk>; [redacted]@rqia.org.uk>; [redacted]@justice-ni.gov.uk>; Durkin, Jacqui <Jacqui.Durkin@cjini.org>; [redacted]@cjini.org>; [redacted]@justice-ni.gov.uk>
Subject: Letter to Minister of Justice from J Durkin re Care and Supervision Review Report
Importance: High

Good afternoon,

Please find attached a letter from Jacqui Durkin, Chief Inspector of Criminal Justice in Northern Ireland for the attention of the Minister of Justice regarding an amendment to an operational recommendation within the Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service (Review report).

I would be grateful if the content of this letter could be brought to the Minister's attention at the earliest opportunity its receipt confirmed at your convenience.

Should the Minister have any queries or questions, please do not hesitate to contact the Chief Inspector or myself directly.

Thank you for your prompt attention.

Kind regards,
Meloney

Meloney McVeigh
Business and Communications Manager

Criminal Justice Inspection Northern Ireland
Block 1, Knockview Buildings,
Stormont Estate, Belfast, BT4 3SJ

Tel: 02890 765742 (Direct Line) or x 89742
02890 765764 (Switch Board)
Mobile: 0772 5581835
E-mail: Meloney.McVeigh@cjini.org

You can follow CJI on Twitter @CJININews and the CJI YouTube channel.

Criminal Justice Inspection
Northern Ireland
a better justice system for all

04 January 2022

Ms Naomi Long MLA
Minister of Justice
Department of Justice
Castle Buildings
Stormont Estate
BELFAST
BT4 3JS

By e mail

Dear Minister,

Criminal Justice Inspection Northern Ireland (CJI) report on A Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service

I hope you had a restful Christmas and wish you a very Happy New Year.

I am writing to request your permission to publish the report on A Review of the Operation of Care and Supervision Units in the Northern Ireland Prison Service (the Review report).

When you requested this Review in November 2020, while mindful of the ongoing COVID-19 pandemic (the pandemic), I believed it was important to commence it as soon as possible given the nature of the allegations and potential issues, particularly for prisoners being held in Care and Supervision Units. This required a multi Inspectorate effort, with all the associated co-ordination, resourcing and risk management issues that entailed, to ensure a robust review was carried out and a report provided to you on our evidence, findings and recommendations.

The Inspection Team was acutely aware of the context and challenges facing the Northern Ireland Prison Service and the South Eastern Health and Social Care Trust during this Review and I know you appreciate our own Team was not untouched by those circumstances either. However, CJI and the Regulation and Quality Improvement Authority (RQIA), as members of the National Preventative Mechanism, and the Education and Training Inspectorate (ETI) are focused on providing professional inspection services and the outcomes achieved for prisoners.

The pandemic cannot be unduly relied upon as the reason why delivery against Human Rights and minimum standards and Expectations for prisoners were not as they should have been. There are many reasons why providing and engaging in meaningful human contact and ensuring prisoners did not experience solitary

confinement was especially important and achievable during the inspection period. I understand that this report contains some difficult messages for the Northern Ireland Prison Service, however, I believe my role is to provide you, criminal justice stakeholders and the wider public, with independent and impartial inspection services and this Review delivers that. As I stated when we met, I also believe you need and deserve adequate assurance based on quality evidence that those standards and Expectations are being met and if not why not. I do not believe that any assurance can be safely provided without sufficient evidence.

There are three strategic and 11 operational recommendations for improvement. I listened carefully to your concerns about Strategic Recommendation 2 and, with the agreement of the RQIA Inspectors, have revised it. I hope it is now accepted for implementation. I also appreciate that the anticipated budget pressures may have an impact of securing resources for those recommendations that require them and that not all of this is within your control. However, given the long standing and well documented nature of some of them, such as scanners and acute mental health provision, I hope they achieve the priority they require to make much needed changes.

I am considering how best to conduct a follow-up review on the Review report recommendations and have been discussing this with RQIA and ETI. I will revert to you on this when the 2022-23 Inspection Programme is submitted for your approval.

I would intend to publish this report shortly after your permission is received, however, if you wish to discuss further please let me know. As usual, we will liaise with your Press Office and the NIPS on draft press releases and advise of the planned publication date.

A copy of this letter and the draft report also goes to Peter May for information.

Yours sincerely,

Jacqui Durkin
Chief Inspector of Criminal Justice in Northern Ireland

cc Peter May, Permanent Secretary, DoJ

Enc

Criminal Justice Inspection
Northern Ireland
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14 January 2022

Ms Naomi Long MLA
Minister of Justice
Department of Justice
Castle Buildings
Stormont Estate
BELFAST
BT4 3JS

By e mail

Dear Minister

Criminal Justice Inspection Northern Ireland (CJI) report on A Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service

I am writing to your further to my letter of 4 January requesting your permission to publish the report on A Review of the Operation of Care and Supervision Units in the Northern Ireland Prison Service (the Review report).

The Regulations and Quality Improvement Authority (RQIA) contacted me after my letter had issued requesting a further revision to Strategic Recommendation 2 as follows:

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 inpatient 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 relevant policy leads in Departments of Health and Justice for consideration by Ministers.

Block 1, Knockview Buildings, Stormont Estate, Belfast BT4 3SJ. t: 028 90 765764 e: info@cjini.org w: www.cjini.org

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The RQIA required some time to discuss this revision with the South Eastern Health and Social Care Trust and I have been advised today that, while the SEHSCT has requested another revision, RQIA want to retain the above version. I have also indicated to RQIA I am content with the above version.

Ronnie Armour has been advised of the revision and has indicated this does not pose any issue for the Northern Ireland Prison Service.

I apologise for this late change to the Review report text and any inconvenience caused to the Northern Ireland Prison Service or your office.

I look forward to receiving your permission to publish in due course.

A copy of this letter also goes to Peter May and Ronnie Armour for information.

Yours sincerely

Jacqui Durkin
Chief Inspector of Criminal Justice in Northern Ireland

cc Peter May, Permanent Secretary, DoJ
Ronnie Armour, Director of Reducing Offending and Director General NIPS, DoJ

FROM THE OFFICE OF THE JUSTICE MINISTER

Department of
Justice
An Roinn Dlí agus Cirt
Mànnystrie O tha Laa
www.justice-ni.gov.uk

Minister's Office Block B,
Castle Buildings
Stormont Estate
Ballymiscaw
Belfast
BT4 3SG
Tel: 028 9076 5725
DOJ.MinistersOffice@justice-ni.gov.uk

Our Ref: CORR-0006-2022

Jacqui Durkin
Chief Inspector of Criminal Justice in Northern Ireland
Block 1, Knockview Buildings,
Stormont Estate,
Belfast BT4 3SJ

19 January 2022

Dear Ms Durkin,

Criminal Justice Inspection Northern Ireland report on A Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service.

Thank you for your letter of 14 January 2022 enclosing your final report on the above Review.

I note the revised text to Strategic Recommendation Two following a request from the RQIA.

I am grateful to you and your team for taking this Review forward, recognising that it was in addition to your work schedule for the year. This is an important piece of work and the Northern Ireland Prison Service has already taken steps to address some of the issues raised within the report.

FROM THE OFFICE OF THE JUSTICE MINISTER

Department of
Justice
An Roinn Dlí agus Cirt
Männystrie O tha Laa
www.justice-ni.gov.uk

I am content to give my permission for you to proceed with publication.

Yours sincerely

Naomi Long.

NAOMI LONG MLA
Minister of Justice

Please ensure that you quote our reference number in any future related correspondence.

Criminal Justice Inspection
Northern Ireland
a better justice system for all

20 January 2022

Ms Naomi Long MLA
Minister of Justice
Department of Justice
Castle Buildings
Stormont Estate
BELFAST
BT4 3JS

By e mail

Dear Minister,

Criminal Justice Inspection Northern Ireland (CJI) report on A Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service (Review report)

Thank you for your letter received yesterday, providing permission to publish the above report.

Unfortunately, following further discussions over the last few days between the Regulation and Quality Improvement Authority (RQIA) and the South Eastern Health and Social Care Trust (SEHSCT) on Operational Recommendation One, RQIA has advised this morning it should be reworded as follows:

The Northern Ireland Prison Service and South Eastern Health and Social Care Trust should ensure that all prisoners are assessed by health care staff prior to a decision being taken to 'award' cellular confinement. This should be implemented within six months of the publication of this report *(paragraph 2.14).*

Changed to:

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 CSU. This should be implemented within six months of the publication of this report *(paragraph 2.14).*

Paragraph 2.14 of the Review report has also been revised to include the sentence in red below:

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.

Obviously, further changes at this late stage are regrettable and the RQIA has advised they will work with the SEHSCT going forward to determine how best to avoid this happening again.

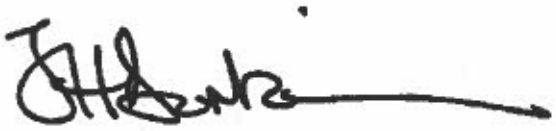
Yesterday, I advised Ronnie Armour that a change to this Operational Recommendation was likely and he helpfully indicated that this would not present an issue for the Northern Ireland Prison Service (NIPS). It will be important that the implementation of this and all accepted recommendations are reviewed and I know the RQIA are keen that this takes place in a timely way.

It would be helpful if the NIPS confirmed acceptance of the recommendations in writing and provided a copy of their action plan in the usual format as soon as possible. I am planning for report publication on 1 February 2022 and we will be liaising with your officials on the draft press release and publication arrangements.

My apologies again for this additional late change to the Review report text and any inconvenience caused to the Northern Ireland Prison Service or your office.

A copy of this letter also goes to Peter May, Ronnie Armour and [redacted] for information.

Yours sincerely,



Jacqui Durkin
Chief Inspector of Criminal Justice in Northern Ireland

cc Peter May, Permanent Secretary, DoJ;
Ronnie Armour, Director of Reducing Offending and Director General NIPS, DoJ; and
[redacted], [redacted], [redacted], [redacted] RQIA,

FROM THE OFFICE OF THE JUSTICE MINISTER

Department of Justice
An Roinn Dlí agus Cirt
Männystrie O tha Laa
www.justice-ni.gov.uk

Minister's Office Block B,
Castle Buildings
Stormont Estate
Ballymiscaw
Belfast
BT4 3SG
Tel: 028 9076 5725
DOJ.MinistersOffice@justice-ni.gov.uk

Our ref: SUB-0027-2022

Mrs Jacqui Durkin
Chief Inspector of Criminal Justice NI
Block 1, Knockview Buildings
Stormont Estate,
Belfast
BT4 3SJ

By email: [redacted]@cjini.org

21 January 2022

Dear Jacqui,

Thank you for your letter dated 20 January containing a further amendment to the draft report which I authorised for publication the previous day.

While it is regrettable that a second amendment is being made at such a late stage, I believe this latest amendment, which addresses the concern we raised with you on receipt of your original draft, is a significant improvement and now compliant with Mandela Rule 46. Consequently, I remain content for you to publish the report on 1 February 2022.

I understand that you are aiming to publish the Magilligan Inspection Report, which I approved for publication on 13 January before the end of February. It is not clear to me why publication of this report is being delayed.

FROM THE OFFICE OF THE JUSTICE MINISTER

Department of
Justice
An Roinn Dlí agus Cirt
Männystrie O tha Laa
www.justice-ni.gov.uk

I am copying this letter to Peter May, Ronnie Armour and [redacted].

Yours sincerely,

Naomi Long.

NAOMI LONG MLA
Minister of Justice

Please ensure that you quote our reference number in any future related correspondence.

Criminal Justice Inspection
Northern Ireland
a better justice system for all

25 January 2022

Ms Naomi Long MLA
Minister of Justice
Department of Justice
Castle Buildings
Stormont Estate
BELFAST
BT4 3JS

By e mail

Your ref: SUB-0027-2022

Dear Minister,

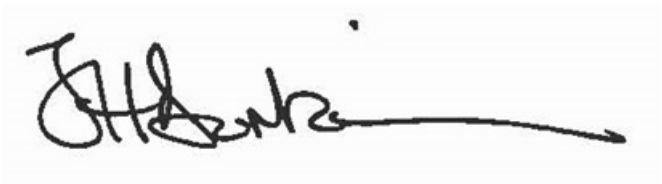
Criminal Justice Inspection Northern Ireland (CJI) report on A Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service (Review report)

Thank you for your letter dated 21 January, confirming your permission to publish the above Review report.

The implementation of the revised operational recommendation will be reviewed in due course. While there was no intention to involve health care staff in adjudication decision making and award of cellular confinement, there were concerns about the timeliness of health care assessment, therefore it will be important that this revised agreed recommendation delivers the improvements to prisoner outcomes intended.

I can advise that the Magilligan Inspection Report is not being delayed; it has not completed report design or required proofing and pre publication stages. It would also be preferable not to publish it immediately after the Review report.

Yours sincerely,



Jacqui Durkin
Chief Inspector of Criminal Justice in Northern Ireland

cc Peter May, Permanent Secretary, DoJ;
Ronnie Armour, Director of Reducing Offending and Director General NIPS, DoJ; and

From: [redacted]
To: R Armour; [redacted] Armour, Ronnie
Cc: [redacted]@justice-ni.gov.uk; [redacted]@justice-ni.gov.uk)
Subject: A Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service
Date: 15 October 2021 15:25:00
Attachments: FACTUAL ACCURACY COMMENT SHEET.docx
NIPS FAC copy 151021.pdf
NIPS letter with FAC 151021.pdf
Importance: High

Sent on behalf of Jacqui Durkin, Chief Inspector of Criminal Justice

Attached please find copy of the above inspection report for factual accuracy check.

Please note the return date of Friday 12 November 2021.

Please acknowledge receipt.

Best regards

[redacted]
Corporate Secretariat Officer

Criminal Justice Inspection
Block 1 Knockview Buildings
Stormont Estate
Belfast, BT4 3SJ

☎02890765764
☎[redacted]
[redacted]@cjini.org
You can follow CJI on Twitter @CJININews and the CJI YouTube channel.

Criminal Justice Inspection
Northern Ireland
a better justice system for all

15 October 2021

Mr Ronnie Armour
Director of Reducing Offending &
Director General, Northern Ireland Prison Service
Room 317 Dundonald House
Upper Newtownards Road
BELFAST BT4 3SU

by email

Dear Ronnie

CJI Review: A Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service (2021)

I am writing to you in your joint role as Director of Reducing Offending & Director General, Northern Ireland Prison Service. As you are aware, Criminal Justice Inspection Northern Ireland (CJI) has undertaken a review of the operation of Care and Supervision Units (CSUs) in the Northern Ireland Prison Service (NIPS). The review follows a request from the Minister of Justice, Naomi Long MLA, to the Chief Inspector of CJI on 9 November 2020.

The Review was undertaken in partnership with the Regulation and Quality Improvement Authority (RQIA) and the Education and Training Inspectorate (ETI). Her Majesty's Inspectorate of Prisons (HMIP) also provided critique as part of existing arrangements to promote conditions and treatment for detainees.

I am pleased to attach a draft copy of the inspection review report for factual accuracy check before publication. Please use the attached pro-forma for your reply. The report will be subject to final proof reading and editing before publication and responses are required on matters of factual accuracy only.

I am also requesting that you develop and provide an action plan as to how you intend to deliver the report recommendations relevant to your organisation.

I would appreciate it if the factual accuracy check and your action plan could be completed and returned by email to [redacted]@cjini.org not later than **Friday 12 November 2021.** I would also be grateful for your assistance in providing a copy of the draft report and the pro-forma to Belfast Metropolitan College with a request that any response should reach us by the same date.

Criminal Justice Inspection
Northern Ireland
a better justice system for all

CJI is grateful to all the officers and staff in NIPS for their assistance in facilitating the inspection review fieldwork, particularly by Governor [redacted] who acted as inspection review liaison.

Thank you for your assistance.

Yours sincerely

Jacqui Durkin
Chief Inspector of Criminal Justice in Northern Ireland

Encs.

Block 1, Knockview Buildings, Stormont Estate, Belfast BT4 3SJ. t: 028 90 765764 e: info@cjini.org w: www.cjini.org

McVeigh, Meloney

From: Durkin, Jacqui
Sent: 13 April 2022 08:16
To: McVeigh, Meloney
Subject: FW: RA to Jacqui Durkin Review into Operation of CSU in NIPS 201021
Attachments: RA to Jacqui Durkin Review into Operation of CSU in NIPS 201021.docx

Jacqui Durkin
Chief Inspector of Criminal Justice

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Jacqui.Durkin@cjini.org
You can follow CJI on Twitter @CJININews and the CJI YouTube channel.

From: [redacted] <[redacted]@justice-ni.gov.uk>
Sent: 20 October 2021 11:11
To: Durkin, Jacqui <Jacqui.Durkin@cjini.org>
Cc: Armour, Ronnie <Ronnie.Armour@justice-ni.gov.uk>
Subject: RA to Jacqui Durkin Review into Operation of CSU in NIPS 201021

Good Morning Jacqui
Please see attached from Ronnie.

Thank you
[redacted]

[redacted]
/Ronnie Armour
Director General, Northern Ireland Prison Service &
Director, Reducing Offending

Northern Ireland Prison Service
028 9052 5[redacted] (ext [redacted])
[redacted]@justice-ni.gov.uk

3rd Floor, Dundonald House, Stormont Estate, Belfast BT4 3SU

Director of Reducing Offending &
Director General, Northern Ireland Prison Service

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Room 317, Dundonald House
Upper Newtownards Road
Belfast BT4 3SU
Tel: 028 9052 5219
Email: ronnie.armour@justice-ni.gov.uk

Jacqui Durkin
Chief Inspector
Criminal Justice Inspection Northern Ireland
Block 1, Knockview Buildings
Stormont Estate
Belfast
BT4 3SJ

20 October 2021

Dear Jacqui

Thank you for copying to me the draft Review into the Operation of Care and Supervision Unit in the Northern Ireland Prison Service, I can confirm that I have sent a copy to colleagues in the Belfast Metropolitan College as requested.

I note your request that we complete the factual accuracy check by 12 November 2021 and I want to assure you that we will do everything possible to do so. However, in view of the extent and complexity of this review and the issues raised as a result of it, it will be necessary to seek legal advice on a number of issues raised. In view of this I may need to ask for an extension beyond the date you have set. I will of course come back to you in advance of 12 November if I need more time.

In the meantime I would like to take you up on your offer of a further discussion about the review. During the meeting I would also want to explain the actions we have taken on receipt of your draft document.

Thank you in anticipation.

Yours sincerely

RONNIE ARMOUR
Director General

McVeigh, Meloney

From: [redacted]
Sent: 19 November 2021 14:04
To: Wilson, Stevie; Corrigan, James
Cc: Erne, Maureen
Subject: FW: Official - Sensitive - A Review Into the Operation of CSU in NIPS factual accuracy response
Attachments: NIPS Themed FAC Response.DOCX; RA to Jacqui Durkin FACS CSU in NIPS 19 Nov 2021.DOCX; Official - Sensitive Special Factual Accuracy points CSU in NIPS.DOCX

[redacted]
Corporate Secretariat Officer

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From: [redacted], [redacted] <[redacted].[redacted]@justice-ni.gov.uk>
Sent: 19 November 2021 13:59
To: Durkin, Jacqui <Jacqui.Durkin@cjini.org>
Cc: [redacted] <[redacted].[redacted]@cjini.org>; Armour, Ronnie <Ronnie.Armour@justice-ni.gov.uk>
Subject: Official - Sensitive - A Review Into the Operation of CSU in NIPS factual accuracy response

Good Afternoon Jacqui

Please see attached from Ronnie Armour. I would be grateful if you would acknowledge receipt.

Many thanks,
[redacted]

[redacted]
/Ronnie Armour
Director General, Northern Ireland Prison Service &
Director, Reducing Offending

Northern Ireland Prison Service
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[redacted].[redacted]@justice-ni.gov.uk

3rd Floor, Dundonald House, Stormont Estate, Belfast BT4 3SU

Director of Reducing Offending &
Director General, Northern Ireland Prison Service

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Jacqui Durkin
Chief Inspector
Criminal Justice Inspection NI
Block 1, Knockview Buildings
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Belfast BT4 3SJ

19 November 2021

Dear Jacqui,

Thank you for the opportunity to provide factual accuracy comments on your draft report entitled '*A Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service*'. This is an important report commissioned by the Minister in the context of a small number of concerns raised with her in the months following her appointment as Justice Minister in January 2020. I am grateful to you and your inspectors for the work that has gone into compiling it, clearly there is learning from this report and we have already taken steps to implement change.

Before commenting further I want to be clear that NIPS is committed to working with all our oversight bodies as we seek to deliver change, indeed your office and HMIP have acknowledged the significant progress we have made in several recent inspection reports. That is not to suggest that we don't have room for further improvement and that is why continuous improvement remains our priority.

It is important, not least in the context of public confidence, that there is a clear understanding of the challenges NIPS face, the context in which we work, and the constraints within which we are required to operate. I welcome the important role scrutiny bodies play in helping us explain the complexities of the prison environment, complexities which in Northern Ireland are compounded by the fact that we do not have the flexibilities of other jurisdictions who have greater scope for the dispersal of prisoners and mechanisms for the transfer and treatment of those with acute mental health issues. I would ask that these challenges are carefully explained in your report.

In responding I want to be very clear that we are committed to make our Care and Supervision Units the best they can be. This report will, I believe, help us in doing so. However, in finalising the report I would ask you to reflect further on the following issues.

The Context – Previous Inspections:

While I accept that the review was an in-depth and focused study, CSUs are an integral part of the prison system and therefore findings should be set in that context and should recognise the work we have done in each of our prisons to address previous inspection recommendations, including those made in relation to our CSUs, by CJINI and HMIP.

I believe it will be important for you to acknowledge, in the context of numerous previous inspections, that many of your findings are new and this is the first time these issues have been raised with NIPS by either CJINI or HMIP. I think it is essential that this is adequately reflected to provide important balance and context for those who will read this latest report.

As your draft report indicates, NIPS is inspected against the HMIP National Expectations and that has been the framework used for the examination of our CSUs during the most recent full inspections? of each of our establishments, including the inspection of Magilligan in May 2021. The draft report from that inspection paints a very different view of the way the CSU operates. That raises an obvious question about whether the same standards are being used in all reviews. Clearly the CSU review, which I understand has been quality assured by HMIP, may have implications for the standards expected for segregation not only here but across the UK. Consequently, it will be important to understand, and would be helpful to clarify in the report, how the standards set will be assessed in terms of all future inspections here and in the rest of the UK.

It would also be helpful to know if HMIP will be requiring the approach outlined in Strategic Recommendation 1 as a benchmark for all future prison inspections when assessing the operation and effectiveness of CSUs. Whilst NIPS will take forward the recommendation on vision and strategy, bullet point 5 in relation to the selection and training of staff will be very challenging to deliver in the dynamic environment in which all prisons operate.

The Context – Covid-19:

Secondly, since March 2020 NIPS has been managing the impacts of the global pandemic. I say that not as an excuse, but rather because it will be important for those reading the report to understand the pressures we were facing as a result of a significant number of Covid related staff absences during the inspection period.

To keep those in our care safe we, like many others across the public sector, have been required to take actions that would not have been our choice. Having effective safeguards in place in prison establishments is especially important given that they are dynamic, residential, communal settings. As such they can be highly prone to outbreaks of COVID-19 as the result of the importation of a single case or cases.

Thankfully, to date, NIPS has been extremely successful; we have only had four positive prisoner cases in the general population, no prisoner has been hospitalised, no prisoner has lost his or her life as a result of Covid and we have maintained an out of cell regime for all those in the general population.

In view of this it is important to acknowledge that while saving and protecting life in our prisons has been our priority, doing so has impacted upon all prisoners, including, those in our CSUs. In presenting your findings I believe this is an important contextual point to recognise.

The Context – NIPS Responsibilities:

Thirdly, it is important to help those reading the report understand what is and what is not within the gift of NIPS to deliver. It is a reality that many of those in our prisons are placed with us because of behaviours that are a consequence of their own vulnerabilities. A fact which is helpfully and clearly explained in the recently published report by RQIA.

I believe that it is important to acknowledge, and I am grateful to RQIA for doing so, that NIPS is simply not equipped and prison healthcare colleagues are not resourced to deal with the complexities that many such individuals present. It is for that reason that many prisoners find themselves in our CSUs, because they exhibit behaviours that cannot be managed elsewhere in the prison estate. Decisions made in this respect rightly require robust evidence. We would be happy to provide you with case studies that demonstrate this point for inclusion in your report.

While I welcome the fact that you recommend (Strategic Recommendation 2) that an alternative must be found for those whose behaviours are a result of issues relating to their acute mental health, it is important to be clear that this is not something that NIPS/DOJ can deliver and therefore such responsibility should not be placed with us.

I believe that RQIA have already accepted and established that point and their recommendations cover similar ground while reaching a somewhat different conclusion.

NIPS Compliance – Mandela Rules:

Turning to Operational Recommendation 1, legal advice suggests that our current practice as outlined in IG 04/18 whereby prisoners are not assessed by medical colleagues before an award of cellular confinement is made is compliant with Mandela Rule 46. Again, it will be important to be very clear in finalising this recommendation what the expectation is as this could have implications beyond NIPS.

In relation to Operational Recommendation 11 regarding the shared CSU at Hydebank, it is important to note that there was a clear separation of male and female prisoners in CSU albeit that the female exercise yard was capable of being overseen by the men in CSU. The move away from having a CSU in Ash House was significantly influenced by previous CJINI findings and recommendations. However, in view of this latest finding, I decided that it would not be appropriate to await a review but rather I agreed with the Governor that the practice should be discontinued. This was implemented on Monday 18 October, three days after we received your draft report. We have reverted to our previous arrangement of confining females to Ash House. While I believe this was a retrograde step because of the negative impact on all females in our care, NIPS does not wish to be in breach of Mandela Rule 11 (a).

In terms of other actions that we have taken since receiving your draft report, I was surprised and very concerned about the conclusion you reached in Paragraph 4.71. NIPS is perhaps the most scrutinised Prison Service in Europe and at no point has either HMIP or CJINI reached such a conclusion before. In view of the implications this will have for NIPS and potentially other Prisons Services, and in the context of the environment in which we were operating during the inspection process, I believe it would be helpful if you would review and comment on the additional measures and recording mechanisms I have now put in place before this report is finalised. I was also concerned that the report did not acknowledge that some of those in CSU were clear that they did not wish to leave their cell or engage meaningfully with staff. I regret this serious issue was not brought to my attention at the time the fieldwork was undertaken.

NIPS – Continuous Improvement Journey:

I am very conscious that CJINI, HMIP and others have travelled with and supported us on our reform journey over the past ten years. Your recommendations and our implementation of them have, particularly since the Maghaberry Report of 2016, rebuilt public confidence in NIPS. Safeguarding such confidence is vital and therefore it is right that you highlight areas where we fall short thus giving us the opportunity to make improvements. I believe that this report will make a significant contribution to the delivery and operation of CSUs moving forward and we have already implemented a range of changes.

However, and whilst not wanting to deflect away from any justified evidence based criticism where presented, it is important that context and balance are also provided throughout the body of the report thus informing the tone and content of the Executive Summary which is the section that will be most widely read. I am concerned that such balance has not been achieved in the draft report.

NIPS – Resource Constraints

Finally, it is important to note, and I would welcome if you would acknowledge in your final report, that considerable resources will be needed to implement your recommendations. At a time when NIPS and the Department of Justice are facing extreme financial pressures, no one should underestimate or be left in any doubt that implementing this report will come at a significant cost. It is important that we are clear that such costs cannot be met to the detriment of others in our prisons or wider justice system.

I have attached for your consideration our factual accuracy assessment, Section 1 explores key themes that we believe emerge from the report and Section 2 explores additional issues not covered by the themes where NIPS considered it appropriate to offer some comment. Naturally I would be happy to discuss our response in more detail if that would be helpful.

Yours sincerely,

RONNIE ARMOUR
Director General

Section 1

CJINI: A Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service (2021)

NIPS Themed Factual Accuracy Response

Key Theme	Factual References	The NIPS Response
COVID-19 Pandemic The COVID-19 Pandemic is an overarching issue for this report and, in our opinion, it does not sufficiently account for the impact of the pandemic on the day to day experience of prisoners and regimes - in reality every aspect of prison life since March 2020 to date. CJINI Review into CSUs (draft) – Executive Summary *"While the COVID-19 Pandemic created some restrictions on engagement, it was the environment..."*	HMPPS COVID-19 Statistics – September 2021 – GOV.UK Page 1 Key Findings *"**234** people in the care of HMPPS have died since the start of the pandemic, having tested positive within 28 days of death or where there was a clinical assessment COVID-19 was a contributory factor in their death. Of whom **159** were prisoners... **19,066** prisoners or children in custody have tested positive for COVID-19 since the start of the pandemic..."* HMIP Full Inspection Report – Hull [July 2021] Para 5.1 *"General time out of cell Time out of cell was very poor. Most prisoners had had as little as one hour a day out of cell since the start of the COVID-19 pandemic this consisted of 30 minutes outside and 30 minutes' domestic time."* Para 3.23 *"Segregation Regime The daily regime and routine was limited to a shower, the use of the telephone and a choice of 30 minutes*	NIPS responded very quickly to the onset of the pandemic and has continued to provide a robust response that has successfully minimised the risk of transmission of this disease into the prisoner population, providing a better outcome for all prisoners across the population including those who are housed within the CSU. Many of the outcomes criticised in this report related to steps taken to manage the pandemic to keep those who live and work in our prisons safe. In order to show this within the report, we would suggest that the following points are described within the report: • During the fieldwork period for this review NIPS experienced its highest level of staff positive tests and self-isolation due to symptoms, household symptoms, close contacts and long COVID. This impacted across all teams and regimes • Only 4 prisoners have tested positive within the prisoner population since April 2020 and there have been no prisoner deaths. 20 have tested positive in committal quarantine, 2 in pre-release testing and 4 in outside hospital – this is in stark contrast to the position in England and Wales • NIPS has not locked landings (as has been the case throughout the UK), but has maintained landing based regimes throughout, including in CSUs • Testing for staff and people in custody in place since April 2020 • Contact Tracing in place from May 2020 for staff and people in custody • Virtual visits were introduced in April 2020 to allow people in custody to maintain family ties. People housed in the CSU have been facilitated to access virtual visits throughout the pandemic • In person visits, when reintroduced, have been accessible by prisoners housed in the CSU, based on risk-assessment • Healthcare staff have maintained contact with those requiring healthcare services, including mental health services throughout the pandemic • Collaborative working between NIPS/SEHSCT/PHA/HSCB throughout • Vaccination has been delivered at the same time as the wider community

	in the exercise yard or 30 minutes on an exercise bike."	
Key Theme	**Factual References**	**The NIPS Response**
Strategic Approach, Governance and Assurance Arrangements This report has omitted the journey that NIPS has been through since the launch of its Prisons 2020 Continuous Development Strategy in 2018 and in doing so presents an unbalanced view. As part of that strategic approach, the new CSU at HBW was delivered and recognised in the HBW 2020 report, yet not within this CJINI Review. CJINI Review into CSUs (draft) – Executive Summary *"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*	CJINI Safety of Prisoners Inspection [November 2019] Executive Summary *I am encouraged by the new approach to managing prisoners at risk; the efforts to extend the reach of the Prisoner Safety and Support Teams; and the embryonic willingness to involve families in trying to work more effectively with some difficult and demanding prisoners. The identification of vulnerability by prison and healthcare staff has improved and critical interventions have undoubtedly saved lives. The efforts to stem the availability of illicit drugs and the use of psychoactive substances are paying dividends [Foreward]* CJINI HBW inspection [June 2020] Para 1.33 *"...impressive...Staff managed the unit with a balance of discipline and kindness, providing a relaxed and therapeutic environment...Decisions to segregate prisoners under rule 32...were recorded appropriately and generally subject to effective managerial scrutiny. We saw evidence that local managers shortened periods of restriction authorised by NIPS*	Since the launch of Prisons 2020 in 2018, NIPS has had a strong strategic approach which has delivered tangible cultural change within a relatively short time period. We recognise that governance and assurance arrangements can always be strengthened and appreciate the points aimed at helping us improve. The report does not contain a rounded picture and we would suggest the following should be clearly laid out within the report: • The continuous development strategic approach implemented by NIPS resulting in a change of culture, delivery of significant change and recognition that NIPS is on a journey that will continue under Prisons 25x25 • HQ governors provide oversight of the rule 32 process. In carrying out this role the governor is acting on behalf of the Department under delegated authority, not as a member of NIPS. NIPS does not agree extensions to Rule 32 and NIPS is not required to exercise governance over extensions – that responsibility sits with the Department • Corporate oversight arrangements are already in place which meet the legal obligation of NIPS. Following the Aiken JR [Oct 2018] NIPS put oversight reviews in place to monitor individuals placed in the CSU on Rule 32. NIPS has significant statistical data which shows clearly that Rule 32 was ended early for a number of people as a direct result of this oversight – in this context, there is no evidence presented in this report of "excessive" use of Rule 32. • Rule 32 extensions are already recorded on the PRISM system and this data is available. The type of data recorded, particularly in relation to case conferences, oversight arrangements and reasons behind decisions could be enhanced though IT development. Oversight is provided locally through the Oversight Committees at each establishment and through the weekly oversight reviews • The Healthcare In Prisons Team were required to comply with the condition that " healthcare staff shall not have any role in the imposition of disciplinary sanctions or other restrictive measures, but should pay particular attention

oversight had enabled varying practices and was hampering opportunities to improve outcomes for segregated prisoners..." *"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 trends"*	*managers if the restriction was no longer justified."* Magilligan IMB Report [2019/20] Page 18 Para 3 *"Although the average time spent in segregation was 7.31 days, (11.38 in 2018/19) one prisoner with complex needs..., remained in the CSU for 77days. Whilst this was considerably longer than the 58 days longest period spent by an individual in the preceding year, prison staff made a concerted effort to produce a sustainable exit strategy"* **Strategic Recommendation 1** • Bullet 1: A framework for the operation of... • Bullet 3: In collaboration with the Department for Justice, a review of Rule 32... • Bullet 4: Effective arrangement for governance, audit and oversight... • Bullet 5: Processes to select, train and support staff...	to the health of prisoners held under any form of involuntary separation." To achieve this they stopped "fitting" for adjudication and CC in 2018, under an agreement with NIPS that provided better outcomes for prisoners held in CSU (which applied to all prisoners entering the CSU, not just CC) • Evidence of individuals who were classed as unfit for adjudication following consideration by a Governor were provided to the Review Team, but were not reflected in the report • NIPS has a number of mechanisms by which lessons learned and good practice can be shared, for example Safer Custody and Security Steering Groups that are chaired by the Director of Prisons, with representatives from all areas Bullet 1 - NIPS aspires to deliver to the Expectations developed by HMIP and this document already provides the required framework. If a separate Framework is to be developed will this become the HMIP assessment framework? Bullet 3: In light of the NIPS response, we suggest that this element of the recommendation is reconsidered in recognition of the governance arrangements that are in already in place Bullet 4: NIPS accepts that we can review and, where appropriate, strengthen our governance and assurance (not audit) arrangements. We recognise that paper records present difficulties. To that end, NIPS has begun a project to implement a full IT solution for CSU management and associated functions Bullet 5: The Review Team is aware that a Review of Support Services for staff has already been undertaken and the recommendations are currently being implemented. We suggest that the "support" element is removed from the recommendation and would also advise that a Learning Needs Analysis for CSU is already planned.

	Operational recommendation 1 Operational Recommendation 8	We suggest that this recommendation is removed as SEHSCT do not (and will not) have any role in the imposition of disciplinary sanctions NIPS has begun a project to implement a full IT solution for CSU management and associated functions
Key Theme	**Factual References**	**The NIPS Response**
Prisoners who have serious mental health and behavioural issues The report does not adequately reflect the challenges of managing people with significant MH/PD issues in a custodial environment who should be cared for elsewhere, but are remanded or committed as prison is inappropriately used as a place of safety. It does not reflect the wider context of under provision of secure mental health beds and MH/PD Services. More importantly, the report does not recognise the extent of care that is provided by NIPS and SEHSCT for these people and NIPS has detailed evidence that we are happy to share.	The Review into Services Provided for Vulnerable People Detained in NI Prisons [Oct 2021] said: *"...we encountered a number of very capable and committed staff across both the prison service and within healthcare in prison. The Expert Review Team was impressed by their compassion and dedication to making things better for people in custody....Segregation in the Care and Supervision Units should be used only for the shortest time possible and as a last resort. Whilst a longer-term strategy is required to increase the number of mental health beds across the region..."* CJINI Report on an Unannounced Inspection of Hydebank Wood Secure College [June 2020] said: Page 4 Para 3 *"Staff managed the unit with a balance of discipline and kindness, providing a relaxed and therapeutic environment. We saw evidence of multi-disciplinary care planning and*	The NIPS shares the concern for these prisoners being housed in the CSU and welcomes that this issue has been raised again, especially following the recent publication of the RQIA Review into the Services Provided for Vulnerable People. However solutions are outside NIPS control. There are a very small number of individuals, given the prevalence of mental health and behavioural issues within the prisoner population, who are housed within the CSU. NIPS and its partners make significant efforts to care for these people, as well as to move them where on where we can achieve that. In order to reflect this we would suggest the following issues need to be clearly explained in the review: • The placement of people in prison is outside of NIPS control, as prisons remain viewed as a place of safety within the judiciary • The wider context in NI relating to the regional lack of provision of secure mental health beds and underfunding of the Healthcare in Prisons Team (RQIA Review Vulnerable People [OCT 2021] • There are dedicated areas within each prison to support people who have additional needs and this needs to be made clear within the report. • People who are vulnerable, mentally unwell or have challenging behaviours are routinely housed within the wider prisoner population. People are only housed within the CSU where there is no alternative • However, sometimes the CSU is the only place within the prison where a person can be managed for their safety or the safety of others • Figures quoted in the report for people who have been subject to a Transfer Direction Order directly from CSU have been included for 2017 – 2020; not 2015-2020 as used throughout the remainder of the report. • People are only housed in the CSU with due consideration and review, taking into account the impact on the individual and others

CJINI Review into CSUs (draft)[2021] *"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..."* *"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."*	*opportunities for prisoners to engage with the wider regime."* Joint CJINI/HMI Maghaberry Inspection [2018] – Para 1.29 *"Inspectors recorded "The monthly oversight meeting ensured that prisoners with more complex needs held in segregation received the support they needed. This was good practice."* Strategic Recommendation 2	• Housing those who are troubled, challenging or have significant mental health issues presents huge disruption and poorer outcomes for others if managed in normal accommodation • Housing those in Ash House who are troubled, challenging or have significant mental health issues causes and need to be segregated for their own safety, or the safety of others has a huge detrimental impact and poorer outcomes for other women who are located within ASH House • NIPS works hard, in collaboration with SEHSCT, to expedite moves to hospital beds • Data on numbers removed by TDO (RQIA Review Vulnerable People [OCT 2021] We suggest that recommendation 2 is out with the control to deliver of NIPS and would ask you to consider directing it to HSCB/Trusts (Review Service to Vulnerable People Detained in NI Prisons [Oct 2021], recommendation 14 refers)
Key Theme	**Factual References**	**The NIPS Response**
Regimes CJINI Review into CSUs (draft)[2021] – Executive Summary	Joint CJINI/HMIP Maghaberry Inspection [2018] – Executive Summary – Safety *"Effective action had been taken to reduce the supply of drugs and the*	NIPS would suggest that appropriate weight is applied within the report to the positive outcomes delivered for those who live and work in our prisons as a result of the NIPS strategy to manage people engaged in the trafficking of illicit and unauthorised articles into our prisons (Rule 32 within Care and Supervision Units). The associated context is also required to give a rounded picture. Data

"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)."	*benefits of this were evident across the prison. The random mandatory drug testing positive rate, for example, had fallen to 9.34%, which was very positive. The search strategy afforded an appropriate response to deter and detect drugs and other prohibited items."* Para 1.31 *"The regime for men staying for longer periods on the unit was good as it reflected plans to reintegrate them to general location. Men staying for short periods could access telephones, showers and outdoor exercise each day. There was a small library on the unit"* Para 1.32 *"Staff managed prisoners confidently and were aware of the individual needs of men in their care. Prisoners we spoke to were complimentary about staff and appreciated the help they received."* IMB Annual Report Maghaberry [2019/20] - Page 11 Para 2 *"The continued entry of illegal drugs into the prison regime remains an ongoing concern. There have been a number of reports of significant incidents within Houses related directly to illegal drugs. Some have resulted in the removal of individuals under 'blue light' conditions to an*	for the same time period examined in this review (2015-2020) evidences that NIPS strategy has contributed to a 61% decrease in incidents and a 79% decrease in assaults (prisoner on prisoner and prisoner on staff) across all three establishments. There is considerable disparity between the content of this report regarding regime including time out of cell and quality of interaction in comparison to previous and recent CJINI/HMI Inspection Reports and IMB Annual Reports. This is very concerning given that previous and recent CJINI/HMI Inspections and IMB reports have not raised any concerns relating to people housed within Care and Supervision Units experiencing conditions "amounting to solitary confinement." NIPS suggests that to provide balance within the report, the following issues need to be clearly addressed within it: • NIPS acknowledges that recording time out of cell and interaction could be improved, however the fact that something has not been written down does not mean it didn't happen and a definitive conclusion that sufficient time out of cell and meaningful interaction was not offered or did not take place cannot be determined on that basis. In fact sections of this report support that individuals are observed having "unlimited access" to the telephone, facilitated with showers and yard time if they chose to engage, which conflicts with other statements made in this section. Para 4.51 *"Inspectors found that no out of cell time measure was available (see Chapter 3) and that existing arrangements failed to provide complete accurate recording methods of time spent out of cell."* Para 4.58 *"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."*

	external hospital. The reality remains however that drugs continue to make their way into the prison. Xanax, Pregabalin, cannabis, heroin and other psychoactive drugs, have been present in the prison at different times throughout the reporting year. Prisoners continue to place themselves and others at risk by bringing these drugs into prison - either voluntarily or through coercion. Whilst there is substantial financial benefit to be gained by individuals who secrete drugs or related items upon themselves, there is a substantial and potentially fatal risk to the individual if anything were to go wrong." **Page 14 Para 5** *"The Board wishes to recognise and acknowledge the hard work and achievements of staff in the CSU in dealing with individuals who present with challenging and disruptive behaviour. On occasions, Board members have observed staff going above and beyond what would normally be expected of them in order to break the cycle some prisoners find themselves locked into. On occasions, staff have built up a level of understanding and rapport, which many prisoners have not experienced before. The Board wish to give*	**Para 4.59** *"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."* **Para 4.61** *"Interactions viewed on CCTV recordings were brief and appeared functional although there was no audio recording."* This section also contradicts the commentary within the Executive summary: **Para 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."* **Para 3.56** *"For those in 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."* **Para 4.61** *"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."* **Para 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."* • NIPS can provide number of case studies which show there is a clear distinction for those on CC • NIPS would suggest that whilst it is recognised within the report, greater weight is given to the fact that there are those within Care and Supervision Units who choose not to engage with the regime or support available despite the best efforts of NIPS staff.

	justifiable recognition to the dedication of staff who have engaged with those individuals." Joint CJINI/HMI Hydebank Wood Inspection Report [2019] – <u>Executive Summary – Safety</u> *"The segregation environment was now fit for purpose, and staff-prisoner relationships were good...Staff managed the unit with a balance of discipline and kindness, providing a relaxed and therapeutic environment."* <u>Para 1.34</u> *"In our survey, only 39% of prisoners who had been segregated said they could go outside for exercise every day, against the comparator of 76%.* ***The records showed that prisoners were routinely offered exercise, a shower and use of a telephone daily but did not always take up these opportunities.*** *Prisoners were seen daily by a governor and a health care professional."* Hydebank Wood IMB Annual Report [2019/20] <u>Page 23 Para 3</u> *"The misuse of, and dependency on, substances - alcohol and both illicit and prescribed drugs - continues to be a major problem within Northern Ireland so it is not surprising that this is*	<u>Para 3.54</u> *"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."* <u>Para 3.57</u> *"Relatively few prisoners made use of outdoor exercise yards.* **It is worth noting that the Inspection took place during the winter.** <u>Para 3.57</u> *"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."* <u>Para 4.57</u> *"The outcomes for individuals varied considerably depending on whether they chose to engage with in the daily routine and/or had other appointments to attend."* • **The regime available to each individual within the CSU does differentiate depending on the reason for restriction of association, needs and risks.** <u>Para 3.52</u> *"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."* • **NIPS would suggest that where specific time periods spent in the CSU's are referred to that the context and circumstances are included as this further supports that there is distinction in the regime available.** • **The report briefly acknowledges the impact of the Covid-19 pandemic on provision for Care and Supervision Units, however NIPS would suggest that greater weight is applied to this within the report given that safety was paramount (see Covid-19 section).** • **NIPS would suggest that due attention has not been paid to the wider context of the rest of the UK in comparative establishments, including the regime available. In conducting their inspections HMIP have remained within their Terms of Reference resting on the requirements under Expectations. The evidence suggests that NIPS have provided a comparative, if not in some cases a superior regime, to Segregation Units in England and Wales. These reports are readily available.**

	mirrored within the prison population. Hydebank, like all other custodial institutions, deals therefore both with the impact substances have had and the ongoing battle to keep them out of circulation. Unfortunately, despite such attempts, the presence of drugs within the prison has continued." <u>Page 49 Para 4</u> *"This year has seen significant change and improvement in the Care and Supervision Unit [CSU] which segregates young men who have transgressed prison rules or whose association is restricted to maintain good order and discipline or to ensure the safety of themselves/ others under Prison Rule 32. In July, a couple of months later than originally planned, a* ***newly refurbished CSU*** *opened on Elm 3. This was managed by the Safety & Support Team, who were involved in the planning and delivery of a new regime with an increased therapeutic focus. The Unit's design has taken into consideration the various senses, with décor and furnishings chosen to minimise tension and assist de-escalation. This new Unit includes a calm room, a private phone booth, a bright and airy dining/ living room with gym equipment, a TV & X-Box. Rooms specifically for interviews/ one to one*	• NIPS welcomes the position that the infrastructure of Care and Supervision Units within Maghaberry and Magilligan be enhanced to include spaces for purposeful activity and association. Funding will be required to enable this. • NIPS acknowledges that record keeping regarding time out of cell and interaction could be improved. In response to this NIPS have approved and began work on an IT solution that will facilitate this level of recording without impacting on the time that staff have to interact with those residing in Care and Supervision Units. It will also evidence when individuals choose not to engage with the regime available to them.

	counselling/ programme work and for adjudications have been included. This is a huge improvement on the previous CSU. Most importantly, cells have been substantially upgraded and designed to create a more therapeutic, normalised atmosphere, all (with the exception of two special accommodation rooms) having plumbed-in cell toilets. The two special accommodation rooms have been provided to replace the traditional 'dry cells' – instead of a chamber pot, they have a portable toilet with a waste trap for recovery of drugs or concealed items. A large yard is available, with outdoor furniture and table tennis which helps reduce tension and aid relaxation. Additionally, acupuncture therapy is provided by staff from Start 360." **Joint CJINI/HMI Inspection Magilligan [2021]** <u>Executive Summary – Safety</u> *"Few prisoners had been segregated in the previous six months. An enthusiastic team of staff on the Care and Supervision Unit provided good support for prisoners, with a suitable focus on reintegration. The recent innovative use of a therapeutic garden helped to improve prisoner well-being in the segregation unit."*	

	Para 1.28 *"During the previous six months, there had been 52 instances of segregation, which was fewer than at the time of the previous inspection and at similar prisons. Although one prisoner had been segregated for 49 days during this period, most stays were short, at less than two days. Around half of all stays on the CSU had been pending adjudication. At the time of the inspection, there was just one person in segregation, who was being managed through an effective multi-disciplinary care plan"* **Para 1.30** *"We observed very good relationships between the enthusiastic unit staff and the segregated prisoner. For example, staff routinely joined him in the therapeutic garden to offer support and maintain a suitable focus on reintegration."* **Para 1.29** *"The CSU had a well-equipped and bright exercise yard. An impressive therapeutic garden, developed by prisoners with the help of a horticulture tutor, opened in 2018. The garden had not been well used until recently but was now helping to improve prisoner well-being (see also paragraph 1.43). Both outside areas provided positive*	

	environments for segregated prisoners and were far better than the exercise areas in most prisons." Magilligan IMB Annual Report [2019/20] <u>Page Para 3</u> *"Drugs continue to be a major problem in Magilligan, as in the other establishments and we are pleased that the Management continue to take robust action against any prisoner, visitor or staff who may be found to be bringing any unauthorised item(s) into the prison, and that they continue to work closely with PSNI to ensure that such individuals face the full rigour of the law."* <u>Page 19 Para 2</u> *"Prisoners accommodated in the CSU are often extremely challenging and the Board wishes to complement the staff on their professionalism in managing them."*	
Key Theme	**Factual References**	**The NIPS Response**
Management and Exit Planning CJINI Review into CSU's (draft)[2021] Executive Summary	Joint CJINI/HMI Maghaberry Inspection [2018] - *"Inspectors recorded* <u>Para 1.33</u> *"The monthly oversight meeting ensured that prisoners with more complex needs held in segregation received the*	NIPS recognises that Care and Supervision Units house people restricted from association for a number of reasons, some of whom are the most challenging and vulnerable people within our care. NIPS makes significant efforts to identify and address the root cause of behaviours that lead to a person having restriction of association. Some cases are more complex than others and we involve others in that response, including, very importantly, our healthcare

"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 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."	*support they needed. This was good practice."* Maghaberry IMB Report [2019/20] <u>Page 13 Para 3</u> *"The CSU Oversight Group which looks in detail at prisoners who have been held in the CSU for long periods, continued to meet on a monthly basis with a purpose of developing exit strategies for those being discussed. This initiative which started in 2017, has been commended by the International Red Cross. Meetings are attended by a member of IMB along with representatives from the Prisoner Development Unit and Prison Healthcare."* Joint CJINI/HMI HBW Inspection [2020] – <u>Para 1.32</u> *"Decisions to segregate prisoners under rule 32 (restriction of association) were recorded appropriately and generally subject to effective managerial scrutiny.* <u>Para 1.33</u> *We saw evidence that local managers shortened periods of restriction authorised by NIPS managers if the restriction was no longer justified…We saw evidence of multi-disciplinary care planning and opportunities for prisoners to engage with the wider regime."*	colleagues. NIPS accepts that paper records can cause difficulties and part of our continuous development strategy includes digitalisation (SPAR Evolution IT solution which delivered an end to end IT solution rolled out between June 2019 and August 2020 to enable our staff to support people at Risk of Suicide and Self Harm). We do recognise that how we record and how we use information related to the recording and consolidation of management and exit planning can be improved. In view of this, NIPS has already approved a project for a radical full IT solution to enable and support the work of Care and Supervision Units. That said, NIPS has a substantial amount of compelling evidence which clearly demonstrates that effective management and exit planning, when required, has taken place within our CSUs. We have a number of detailed case studies available, some of which are individuals referenced to within this report, which are available to you. The case studies are end to end and provide the complete detail, not the chosen aspects reflected in this report's "Case Reviews" which paint a very different and, in our view misleading, picture. NIPS suggests that for a balanced portrayal, the following points need to be reflected clearly within the report: • There is a considerable contrast between the content of this report relating to management and exit planning when viewed alongside previous CJINI/HMI Inspections and feedback received from Independent Monitoring Boards (please see included extracts.) • NIPS would suggest that greater weight is applied to the impact that the pandemic has had on multi-disciplinary input to the Rule 32 process and therefore in some instances management and exit planning *(see key theme pandemic).* • Unsubstantiated statements about management and exit planning should not be used when contradictory commentary s contained elsewhere in the report. For example: <u>Executive Summary</u> *"At Maghaberry in 2018, exit planning for the longer stayers was good, but generally, this work had taken a backwards step across all prisons."* <u>Para 3.46</u> *"Inspectors observed a Rule 32 oversight meeting at each prison and reviewed a selection of minutes of previous meetings. There was clear*

	Hydebank IMB Report [2019/20] Page 51 Para 4 *"The Board is committed to its role within the R32 process and attendance at Oversight Committee meetings, particularly in encouraging a purposeful and therapeutic regime within the CSU and development of a clear exit strategy for each student."* Magilligan IMB Report [2019/20] *Page 18 Para 3 "Although the average time spent in segregation was 7.31 days, (11.38 in 2018/19) one prisoner with complex needs, who maintained a prolonged dirty protest, remained in the CSU for 77days. Whilst this was considerably longer than the 58 days longest period spent by an individual in the preceding year, prison staff made a concerted effort to produce a sustainable exit strategy"* Joint CJINI/HMI Magilligan Inspection [2021] – Para 1.28 *"At the time of the inspection, there was just one person in segregation, who was being managed through an effective multi-disciplinary care plan (see also paragraph 1.43)."* Para 1.30 *"We observed very good relationships between the enthusiastic unit staff and the segregated prisoner. 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."* • Management and exit plans will differ based on the needs of the individual and why they are in a Care and Supervision Unit. A "one size fits all" approach cannot be applied. The reality is that some individuals will require complex and intricate management and exit planning whilst others will not. (Executive summary *"Overall, the plans identifying exit and reintegration pathways were inconsistent and in some instances did not exist at all."*) • The evidence considered and presented within this report needs to be comprehensive and reflect the evidence that is available and not limited to the content viewed during fieldwork and PRISM records. Para 3.78 *"There was limited evidence in the paperwork provided that reintegration plans were routinely developed for those leaving CSUs."* Para 3.48 *"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 was no evidence to at subsequent reviews of a follow up resolution."* In this case, for example, NIPS has evidence that the librarian was engaged in extensive work with this person to support him to address this issue. • NIPS would suggest that consideration is given to the fact that although illicit or unauthorised articles may not be recovered directly from an individual, this does not mean that the suspicion of possession/secretion is not valid. Whilst items were not recovered directly from the individuals referred to in the paragraph below there is other evidence available that supports the suspicion of possession of illicit and unauthorised articles. Para 3.24 *"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."* The paragraph below (Maghaberry IMB Report 2018/19) is an excerpt from a wider section and the entirety of the section is quoted or the excerpt is removed. It is extremely misleading to quote just this section.

	For example, staff routinely joined him in the therapeutic garden to offer support and maintain a suitable focus on reintegration." Para 1.43 *"We observed individualised and integrated care delivery in the CSU, where prison officers, supported by the PSST and Mental Health Team, delivered an imaginative and complex social care package3 to a highly vulnerable young man. This included use of the integral therapeutic garden and gym as part of a graduated exposure plan to enable reintegration into the prison (see also paragraph 1.30)."*	*"IMB Annual Reports for Maghaberry had raised concerns that individuals were held for significant periods and that a 'find' was only recovered in 35% 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."* • The report acknowledges that inspectors found some good examples of individually tailored care plans but does not elaborate further on these examples. Executive Summary *"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."* Para 4.46 *"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."* • Good practice should be clearly identified and examples provided.
Key Theme	**Factual References**	**The NIPS Response**
Learning, Skills and Activity This report implies that restrictions on access to Learning and Skills has been applied only to people housed within the CSU which was not the case. CJINI Review into CSUs (draft) *"A small number of tutors had visited prisoners who were enrolled in their classes in order to deliver*	CJINI Inspection Hydebank Wood [June 2020] - Para 1.34 *"The records showed that prisoners were routinely offered exercise, a shower and use of a telephone daily but did not always take up these opportunities."* HMIP inspection Wormwoods Scrubs [June 2021] – Para 2.28 *"The regime was poor, with prisoners having only 30 minutes a day out of their cell for exercise and a shower; we were told that this could be increased*	NIPS takes the provision of learning, skills and activities very seriously and would appreciate the inclusion of the significance of the Pandemic and its effect on L&S provision, especially during the period of this review, reflected in its commentary. We would ask that the following points be reflected clearly within the report: • At the time of the fieldwork for this review, no teaching staff were on site in our prisons due to the wider government "stay at home" policy • There was no learning and skills provision from March 2020 for all people in custody, not just those held in the CSU • Not all people who are moved to the CSU are enrolled on courses through L&S. • A new contract and SLA for the provision of Learning and Skills was let in April 2021, with a single provider, which will ensure consistency of delivery

workbooks, practice exams or to provide certificates of achievement to those due for discharge."	*if staffing levels allowed. The two exercise yards used by the segregation unit were bleak and had graffiti on the walls."* (comparison with segregation regime in English Prison) CJINI Inspection Maghaberry [April 2018]- <u>Para 1.31</u> *"The regime for men staying for longer periods on the unit was good as it reflected plans to reintegrate them to general location. Men staying for short periods could access telephones, showers and outdoor exercise each day. There was a small library on the unit."* Strategic Recommendation 3 Operational Recommendation 6 Operational Recommendation 7	across all sites, including provision of L&S to people who are housed within the CSU • For people housed within the CSU, access to learning and skills is subject to risk assessment as the safety of others has to be maintained • Local arrangements are in place at each establishment to notify L&S when someone is relocated to and from the CSU • During the fieldwork period (January/February 2021) the weather was extremely cold, with snow on some days. It is unsurprising that people were reluctant to use outside facilities • Where risk assessments allow, people housed in the CSU can attend classes external to the CSU • The action plan under the new SLA with Belfast Met in place from April 2021 includes the action to *"Test the products/content to ensure it meets NIPS expectations in terms of quality for its users and availability in different prison areas including Care and Supervision Units."*[Virtual Learning]. This underlines the NIPS/Belfast Met commitment to extending access to people in CSUs • NIPS staff and the Prisoner Engagement Team within SEHSCT have put a lot of effort into developing and providing distraction packs for people in prison, which includes those housed in the CSU. These packs are readily available, but again, it is down to prisoner choice as to whether they want to avail of them. • Library services, distraction packs and physical activity are provided through NIPS, not through Belfast Met. NIPS views L&S provision as a priority and will continue work with Belfast Met to ensure access. We would suggest that the recommendation is reworded to reflect that library services and physical activity does not fall within the remit of Belfast Met Local arrangements are in place, however NIPS will review to ensure that communication channels are clear and operational This is a repeat recommendation and we suggest that the timescale quoted is unreasonably short

Key Theme	Factual References	The NIPS Response
Provision for Women CJINI Review into CSUs (draft) – Executive Summary *"The shared Care and Supervision Unit at Hydebank Wood for young men and women did not provide "entirely separate" facilities. This was out of step with the Mandela Rules and with HMIP 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 CSU."* CJINI Review into CSUs *"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*	Joint CJINI/HMI inspection of Ash House June [2020] stated in the Chief Inspector's foreword: *"Ash House was last inspected in May 2016, and before that in 2013. In 2013 it was judged that three of the four healthy prison tests were either 'poor' or 'not sufficiently good' with only safety found to be 'reasonably good'. By 2016, significant progress had been made with improvements in three tests. This report shows even more marked progress with improvements in three of the healthy prison tests judged to be at the highest standard, 'good', and in particular, respect had improved from 'not sufficiently good' to 'good' – an increase of two grades and a very significant achievement."* *"There is a small amount of well-managed contact between the male and female prisoners, which has caused some discussion as to whether this is fully in accordance with international standards concerning the separation of the sexes in the custodial environment. Our observations during this inspection, supported by observations from both male and female prisoners, is that if properly supervised and managed, such contact*	The report does not contain much content related to the housing of women within the CSU and the author has taken a position which is directly contradictory to the published HBW inspection report of June 2020. NIPS suggests that the following points are considered and reflected clearly within the report: • The PRT report [2011] is 10 years old. The reference to the PRT Report 2011 does not add to the commentary as it conflicts with the most recent joint CJINI/HMI Inspection of Ash House [2019], which comes to a contrary conclusion. The PRT report does not make any specific reference to segregation in Ash House and is therefore irrelevant to this report (the last line of para 4.17 of the report is inaccurate and misleading. Para 4.17 "'*The review of the Northern Ireland Prison Service*' (referred to as the PRT report), 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*'. It reported the prison to be 'wholly unsuitable' and that assessment reflected considerations to specialist needs such as segregation." • NIPS aspires to achieve the Expectations laid out in the Expectations documents and would expect to be assessed against these, as laid out in the terms of reference for this report • The shared CSU, as having a purpose built and modern design, could not be described as "*...designed for men and merely adapted slightly to accommodate women.*" • NIPS would suggest that the report should include an accurate depiction of the "shared CSU". The current wording implies that males and females were held together, which is untrue. Male and female occupants were, in fact, located on different landings, Elm 1 (male) and Fern 1 (female). Whilst occupants have access to the same communal areas this access was controlled and closely managed to prevent contact, with communal areas being used by males and females at different times.

premises allocated to women shall be entirely separate. HMIP expectations for woman are underpinned by an ethos that woman, '...should no longer be held in custody which was designed for men and merely adapted slightly to accommodate women'.[31] The recent change in CSU at Hydebank from young men only to one now shared with women prisoners was a serious concern to inspectors."	*can be of considerable benefit to both men and women. The then two Chief Inspectors at the invitation of a group of women, joined a group discussing the impact of trauma, and they were very clear in their views that there were distinct benefits to properly controlled contact."* Para 1.57 *"In our survey, all women who had been segregated said they had been able to shower, take exercise and use the telephone every day. We saw segregated women having more than one hour a day out of their cell. We were assured that segregated women saw a governor every day, but records of visits by health professionals were less reliable."* Executive Summary – Safety *"Women were segregated on their units, generally for short periods, and were positive about their treatment while segregated."*	• In the absence of funding for the long-awaited new female facility, NIPS has been innovative in responding to, and managing, the challenges faced and this clearly reflected in the HBW June 2020 inspection report. • Where there is reference to a specific time period that a female spent in the CSU the context and circumstances should be included, particularly in the case referenced below as it is fully reflective of the level of care and support provided whilst highlighting the challenges faced within NIPS Care and Supervision Units. Stating a figure only is emotive and only tells a small part of the story. Para 4.22 *"One woman had been held in the CSU for more than 42 days."* • The report should acknowledge the extreme disruption that is caused to other women in custody when Ash House is used to house women who are segregated. It was in recognition of this that Fern 1 was established, which provided a benefit and better outcomes for women in Ash House. It also provided a benefit and better outcomes for women segregated in Fern 1 through a smaller prisoner to staff ratio enabling additional input from staff; as well as modern facilities and access to the communal areas of the CSU (carefully managed and at times when young males were not present.) Para 4.20 *"Several 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 had on the whole environment and the efforts of staff to maintain privacy and dignity for the individual concerned."* Hydebank Wood Annual IMB Report 2019/20 *"It remains disappointing that there is still **no specific area/ Unit for female prisoners** who are **assessed as requiring segregation**. Instead, female prisoners are segregated in their own cell or in a part of Ash 1 landing that can be separated by a gate. This has an impact on the other women on that landing who are locked while those segregated are 'out of cell'. Whilst it may have been an untypical situation, it was concerning that in January 2020 seven women on R32 were confined to their cells on A3 and A4, which affected the other women and placed additional stress on the staff on these landings. It would appear, until a*

		bespoke and independent Women's Prison is in place, such unsatisfactory situations may continue. However, as with the introduction of Fern Unit for committals, some thought should be put into the creation of a more purposeful and therapeutic area for those women who require segregation."

SECTION 2

CJINI Review into the Operation of CARE AND Supervision I=Units in the Northern Ireland Prison Service - draft	
Specific accuracy point	**NIPS response**
3.4, 3.40, 3.52, 3.57, 3.58, 3.65, 3.84, 3.96, 4.60 Comments made by 1 prisoner/member of staff quoted	Subjective statements frequently stated as the view of one individual, or an unquantified few. There is a risk that undue weight is being applied to those single comments.
1.9 bullets	Include: 32 (1A) should also be quoted as it is relevant to the use of rule 32 for the retrieval of any unauthorised or prohibited article and Prison Rule 95 relating to disciplinary awards for YOC
3.8 "There was no designated sluice room..."	NIPS has received health and safety advice that sluice rooms are required in Healthcare setting for the disposal of medical waste. The disposal of urine when special accommodation is in use in a toilet is acceptable practice.
3.10 *"...and observation cells for those deemed at risk of self-harm..."*	Observation cells may be used for a number of reasons, not just for those at risk [prison rule 47/48A]
3.17 *"This included one who had been held for 366 days."*	The lack of context portrays an inaccurate picture provided. There is no recognition of the efforts staff have made to care for this individual.
3.18 "It was double at Hydebank where..."	This statement is inaccurate. The actual numbers, as well as percentages, should be specified. The low prisoner population at HBW would expectedly produce a higher percentage text. The paragraph does not include the context of the reason why prisoners were in the CSU (which may have been related to revised strategy to tackle substance misuse and trafficking) and therefore presents a misleading picture. Maghaberry average population 2011 – 2020 – **937**

	Magilligan average population 2011 – 2020 - **486** HBW average population (male) 2011 – 2020 – **128** HBW average population (female) 2011 – 2020 – **59.6** HBW average population (male & female) 2011 – 2020 – **188**
3.20 *"During 2020, the application of Rule 32 had reduced because of efforts to reduce the movement of prisoners…to manage the risk of COVID-19…"*	This is inaccurate. The reduction in rule 32 was directly related to the reduction in trafficking into the jail, as a result of 14 day quarantine arrangements under COVID-19 response.
3.21, 3.22 *"…and this was not a positive outcome for prisoners."* *"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 2017 to 14 days for males and 12 days for females."*	This statement is inaccurate. This was a **very** positive outcome for the general prisoner population as the reduction in the supply of drugs led to a much more settled general population, with fewer incidents etc. The next para notes the "significant reduction" in the length of average stays in MGBY, which again shows a positive outcome for prisoners. The HBW figure quoted needs to also state what it increased from. The figures quoted are incorrect: Hydebank 2017 average duration of stays 2017; Male – 9 days Female – 5 days
3.23 "In 2018, one individual spent 69 days in a drug recovery cell at Magilligan." *"In 2020, the maximum length of time a prisoner spent…"*	As highlighted before, the context behind the individual being in a drug recovery cell is critical to understanding, rather than just giving an overall figure. NIPS has this information and is happy to share it. Again, the figures are meaningless without the context in which those individuals were in the CSU.

3.27 [Page 29] and chart 3 [P30] *"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)."*	This statement is inaccurate. The year 2020 was omitted from this data set – apparently due to the pandemic – yet was not omitted from the data set at Chart 2: Rule 35 (4). When 2020 is included, it shows a very different picture, with a significant downward trend for males at HBW. The paragraph and the Chart should be redrafted/replaced 10 Year Dataset - Combined - Amende
3.31 [p30] *Records need to contain greater detail along with evidence that prisoners fully understand the rationale for decisions to segregate in the CSU."*	Advice on how NIPS can "evidence" that a prisoner understands would be appreciated.
3.37 [p32] *"During the pandemic IMB members were not permitted to attend Rule 32 reviews for a period and arrangements were made to review documentation away from the CSU."*	This is not accurate. At the time it was the choice of IMB members not to attend mostly because most of their members were isolating due to Government Guidance.
3.39]page 32] *"Requests to extend segregation periods under Rule 32 were agreed by a HQ Governor"*	This statement is inaccurate. The extensions are considered and agreed by a Governor from HQ who is not acting as a Governor, but as the independent Authorising Officer on behalf of the Department of Justice.
3.41 [page 32] whole paragraph	Existing arrangements for Rule 32 case conferences are that Healthcare in Prisons team, PSST, Security, IMB, Govs are invited to attend each case conference. Perhaps a recommendation here is appropriate for SEHSCT.
3.43 [page 33] *"At Magilligan and Hydebank they were chaired by the Deputy Governor and at Maghaberry chaired by the Functional Head of Residential and Safer Custody".*	These posts are all at the same rank – it reads as though lesser importance is applied at MGBY, which is not the case and therefore inaccurate.
3.44[page 33] *"There were gaps in contributions, for example, from learning and skills and psychology staff."*	NIPS forensic psychology, or SEHSCT clinical psychologists? The statement is inaccurate as it implies that these staff were on site and accessible – at the time of the fieldwork, these staff were not on site in the prisons.

"Both had significant contributions to make...	Perhaps replace "had" and insert "may have had"
3.50 [p34] *"Maghaberry had commenced a new monthly Rule 32 audit but largely focussed on procedural practice rather than on improved outcomes for prisoners."*	That is exactly what it was meant to do – it encouraging that inspectors have confirmed it was working effectively, but disappointing that it has been turned it into a negative.
3.55 [page 35] *"In response to the same question, 46% of the general population in Maghaberry responded 'No', while at Magilligan in 2017 this was just 10%."*	If the issue being raised is Maghaberry what relevance does Magilligan responses have? Is there data available as to how the Maghaberry survey responses equate to comparative prisons?
3.67 [p38] *"Two pieces of gym equipment were also available in the CSU recreation room but inspectors did not observe them being used."*	By prisoner choice? Prisoners cannot be compelled to use equipment
3.68 [p38] *"The benefits of a full-time and qualified librarian was strongly evident"*	Maghaberry also has two librarians – the wording of this sentence has the potential to criticise the work that they do as it is officers fulfilling this role.
3.71 – entire paragraph	The wording of the paragraph presents an inaccurate picture. In completing daily request sheets/journals, CSU staff are fulfilling the need to have operational records to enable us to complete everyday tasks. The purpose is not to provide "longitudinal information".
3.73 – *"several prisoners said if they had wanted to speak to the Governor about something personal it would have been awkward, as everyone could have heard them, including other prisoners"*	This is personal opinion and appears to be hypothetical – there is no specific instance(s) quoted where this had actually happened.
3.74 [p 40] *Records Inspectors examined did not demonstrate that Duty Governors routinely checked landing journals or requests sheets to inform their visits with prisoners and that they relied on officers to confirm what requests had been made by prisoners.*	This statement is inaccurate. Request & Complaint system is fully automated and does not necessitate the checking of request or complaint sheets by Duty Governors unless that request or complaint has been forwarded to the individual or department. If a formal written request is submitted, it will be recorded on PRISM and directed to the most appropriate person – other non-formal or verbal requests are managed at a lower level and could be reported via word of mouth if appropriate.
3.76 [p41] *"IMB weekly visits to CSUs had resumed at Maghaberry but not at Magilligan and HBW"*	Each establishment had agreed through the Executive Forum that IMB could come on site and all the paperwork would be brought to them – in MGN they used their own office, the paperwork was photocopied, placed in clear sleeves and they used PPE gloves during their reviews. This was consistent with MGN and HBW. The context of the pandemic here is important as most of the IMB members were self-isolating due to Government advice. In the absence of the context, the comment is misleading and inaccurate.

3.77 [p41] *"...risk assessment or problem formulation."*	This statement is inaccurate. As commented on earlier, this sits with the healthcare assessment on entry to the CSU and followed up by daily visits. Any concern whatsoever about the individual can be picked up by the medical professional, or through member of staff notifying a healthcare professional. Where there is a concern that someone may be at risk of suicide or self-harm, the SPAR Evolution approach applies as it does for any other prisoner, irrespective of their location in the prison
3.81 [p42] *"The NIPS estate has no health care in-patient facility".* *"Exit planning was also considered at oversight meetings and these measures were documented on separate proformas and by those considering extension requests."*	This is entirely in keeping with the Expectations standards for Health, Wellbeing and Social care (Patients receive secondary care services within community).The SEHSCT direction is that prisoners who need hospital treatment will be assessed/treated in a hospital. NIPS facilitates this to happen. The text should reflect this. Rule 32 oversight meetings are not for the purpose of considering an extension. Rule 32 oversight meetings examine the current status, provision and if an early review for exit from Rule 32 is appropriate.
3.80 [page 42] *"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."* 3.82 [page 42] *"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."*	Is this not contradictory to the previous statement regarding Governors' fitting people for adjudication and also the reference to SET not fitting people for adjudication (3.83). This also demonstrates that the process under IG 04/18 is effective.
3.84 [p 43]"However, *some prisoners told inspectors about long waiting times to see a GP, although this was comparable to waiting times in the community"*	Opinion, not fact – it should be noted that waiting times in prison are comparable to the community?
3.86 [P43] footnote 22 *"...called SPAR (Supporting Prisoners at Risk)..."*	This statement is inaccurate. SPAR (Supporting **People** at Risk) Evolution.
3.94 [page 45] *"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."*	This is out of context and therefore inaccurate, the job role information provided was for the purpose of outlining operational responsibilities, not for the recruitment of staff to the CSU.

3.96 [p45] examples.	The reporting is unbalanced with one positive quote about staff and 3 negative (which is an inaccurate portrayal). All four quotes are opinion based- not fact. The reviews carried out on SPAR Evo reflected very positive quotes about staff.
3.101 [P46] *"Formal training was not provided to Governors in applying rule 32, 35(4) and adjudications or those responsible for extending Rule 32.*	This is inaccurate. In September 2015, following promotion boards to Unit Manager, formal training in adjudications was delivered to 13 newly promoted Governors and 1 existing Governor. Formal training was required for every governor and was delivered by a suitably qualified practitioner and a list was maintained of those who completed the training and found suitable, as far back as the last 15yrs "Judge Over My Shoulder" training has been delivered to Governors by DSO, and by the NIPS Legal Adviser who holds a formal training qualification. A number of 1-2 hr training sessions were delivered to Governors between the end of 2018 and beginning of 2019 at each establishment and NIPS HQ by our Legal Adviser. The sessions covered the requirements under the Rules and discussing cases that had gone to court in great detail. A further part of the sessions was delivered by Counsel specifically in relation to giving a gist to the prisoner at the invocation of Rule 32. Furthermore, as a result of the sessions and the Aiken case, all establishments introduced the weekly informal review of those on Rule 32, which is over and above the requirements under the Rules. It is also interesting to note that the number of legal challenges around the invocation of Rule 32 has significantly reduced. During the review of CCTV footage at NIPS HQ, the NIPS legal Adviser offered to speak to the Inspector, but that offer was not taken up.
3.107 [47]	A pilot re recommendation 7 of the support services review report starts in HBW on the 01 November 2021
4.7 [p49] *"...prisoners at all sites still referred to the CSU as, "the block..."*	People in custody have nicknames for most things. For example, people in custody frequently refer to officers as "screws" and prisons as "jails". The connotation is misleading and therefore inaccurate
4.8 [p49] *"The adjudication procedure "awarded" punishments that resulted in prisoners being sent to the CSU with an outcome resulting in segregation in cellular confinement."*	The drafting is misleading/inaccurate as it does not include the other awards that can be made (and more importantly are made) under Rule 39. It does not include the volume of other awards v awards for cc. It implies that cc is the

"It is the view of the 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 the use of the CSU was not limited to just punishment but extended far beyond this;"	only award that is made following the adjudication process, which is inaccurate. It furthermore does not add any context as to the story behind why an individual has been awarded cc in the first place. Could the author explain what they mean by *"not limited to just punishment but extended far beyond this"?*
4.9 [p49] whole paragraph	This para is contradicted by others throughout the report including 3.81 – 3.91, 3.62, 3.65-3.68 and others.
4.10 [p49] whole paragraph	Prison Rule 39(4) provides for where a prisoner is found guilty of more than one charge arising out of an incident. The context of the reasons why the individual has been awarded cc is missing, as is the extent to which this is an issue, which presents an inaccurate picture. The NIPS adjudication manual states at para 6.11, "generally adjudicators should only award cellular confinement in respect of serious or repeated offences."
4.11 [p49] *"...where a prisoner already in the CSU on Rule 32 was punished through demotion in regime under PREPS."*	The context as to the circumstances leading to the demotion under PREPs needs to be understood. If inspectors expect the same level of access and treatment across general population & CSU, then it must also expect that rules re the conduct of those held within the CSU and the general population also need to be applied in the same way.
4.15 [p50] *"those at Maghaberry were either accommodated in dry cells, which were particularly Spartan, or placed in other cells without a toilet and provided with a chamber pot"*	Dry cells are those cells without a toilet in which chamber pots were used – the wording of this is inaccurate and suggests we have both dry cells and cells which do not have toilets, which is incorrect.
4.16 – *"no evaluation/review had been conducted of either Davis House....."*	In keeping with the rest of the world, we have been responding to a pandemic where only essential staff are permitted into the prison to minimise the risk of transmission of COVID-19 to the prison population and this is rightly where our focus has had to be. Review will be completed if appropriate and at a time when NIPS has the capacity to do so. This statement inaccurately portrays the position by omitting the context of the pandemic.
4.20 [p51] *"Several mentally unwell women had been held in the CSU ending transfer on TDO since its opening."*	How many, for what duration and what was the context behind their removal to the CSU? It is unlikely that efforts to maintain privacy and dignity for the

	individual quoted would have been any less in Ash House.
4.22 [p52] figures *"Some individuals were segregated for significant proportions of their overall time in custody"*	The figures are not helpful without the context of why the individuals had been segregated under Rule 32 – particularly the one woman segregated for over 42 days. How many is "some"? What constitutes "significant" proportions of overall time in custody? An accurate account cannot be established with this information missing.
4.23 [52] *"However, the data did not show how many previous extensions there had been."* *Inspectors noted that it was not routinely captured and used...*	This data is available on PRISM and available on hard copy if requested. The statement is inaccurate as had it been requested, it would have shown extensions etc. All data on Rule 32s with regard to the start and end dates and the number of extensions are captured as confirmed in 4.25. I would suggest of more importance than the number of extensions is the overall time a person spends on Rule 32. In theory all Rule 32s could be extended for up to 28 days at each extension; the fact that they are not, shows that NIPS operates according to the specific circumstances of each Rule 32 and the changes that can take place during the period on Rule 32 and; therefore, no one spends any longer on Rule 32 than is necessary.
4.24 [page 52] *"Those that ended before reaching the authorised limits, generally, ended between one and three days early. It could not be determined from the data if they had ended due to decisions made by Governors at prisons or by the HQ Governor responsible for overseeing and agreeing requests to extend Rule 32"* *"NIPS need to better understand the reasons why Rule 32's end early and use this learning to influence better outcomes for other segregated prisoners."*	This is incorrect, it would be a local decision to end the Rule 32 early due to an oversight meeting. The Governor attending is for the purpose of authorising or not authorising the extension period when the current period is about to expire, and on behalf of the Department. This is an inaccurate statement. Each case is an individual and those that end early are due to the risks that led to an individual being on Rule 32 reducing in their particular circumstances.
4.30 [p54] *As reported in Chapter 3, the data indicated that the duration*	This is inaccurate. Cellular capacity was increased for males when the CSU was

of stays for young men at Hydebank Wood had increased in particular. The capacity of CSU accommodation[35] 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.	relocated from the old CSU to Elm 1 CSU and was attributable to the cells available on the existing landing – not because of a desire to increase the number of people who could held (which the drafting implies) Four cells were made available on Fern 1 CSU as an annex of the existing Fern 1 landing, which had previously been redesigned to accommodate a republican prisoner and was more recently used by kitchen workers. Available space was reduced from the six cells that were previously available on Ash 1 to four on Fern 1 CSU. The capacity per 100 prisoners are always going to be much higher at HBW due to the small young offender and female populations. The paragraph should reflect this, as it is misleading as it stands. It also does not reflect the different needs/responses related to female and young offender populations
4.31 [page 54] *"The NIPS advised it was waiting on final authority from the Department for the Economy to introduce scanners and they had well progressed plans in place for staff training and implementation."*	Please replace the Department for the Economy with a Justifying Authority
4.33 [p55] whole paragraph	This is inaccurate. Under SPAR Evolution "SPAR" stands for "Supporting People at Risk" and it is a multidisciplinary approach which is person-centred and aims to support people through a period of crisis or distress, while also addressing the root-cause of the crisis or distress where possible.
4.34 [p55] *"From 01 January 2015 – November 2020 8% 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 time almost one fifth of female prisoners (18 %)..."*	These figures are not accurate. Checks by NIPS staff have shown that individuals who were on a SPAR at the time they were charged or adjudicated on, were not on a SPAR or (Care Plan under SPAR Evo) when they entered the CSU. From 2015 – 2020 **7%** of males were on a SPAR when placed on Rule 32 which is 369 instances and 187 individuals across the three establishments. Also there is no context provided, below is an example of when this has occurred; *Prisoner A is committed to custody on 14/02/20, they present as under the influence and during the committal interview and advise staff that they have a history of self-harm. The individual disclosed that they had taken a substantial*

	amount of drugs prior to entering custody and could not confirm if they were able to keep themselves safe, A SPAR Evo was opened. *Due to the individual presenting as heavily under the influence there were concerns that they may have items concealed on their person and are placed on Rule 32. As nothing had been recovered from the individual and they were no longer presenting as under the influence they were relocated from the CSU to general population. On that same day a package was recovered from the individual's cell and they were returned to the CSU and placed on Rule 35(4). The individual was then placed on Rule 32 due to ongoing concerns that they had items concealed on their person. During this period of Rule 32 there were two periods of 7 day extensions requested and authorised. The SPAR remained active during this time to provide the individual with the appropriate support and was closed 5 days after the conclusion of the Rule 32.* The total for females is incorrect, this is 14%. Again there is no context provided in terms of the population size which results in a higher percentage. From 2015 – 2020 the total number of females that were on a SPAR when placed on Rule 32 is **14.** Overall the data demonstrates that the number of individuals placed on Rule 32 when subject to SPAR/SPAR Evo monitoring is on a downward trend during this same time period. Please also note that this data highlights if a SPAR is active on Rule 32 date. This means that in some instances the SPAR may have been opened after the commencement of Rule 32.
"If that trend continued, 18% of women would be on a SPAR when they went to the new joint facility"	That is pure supposition and has no basis bearing in mind a) the figures quoted are not sound and there has been no analysis made of the period October 2020 – Feb 2021 when the field work was being completed.
4.35 [p55] Whole paragraph	This is inaccurate. The old SPAR Process and SPAR Evolution are multidisciplinary, with input from healthcare. Under SPAR Evo, where an individual is known to the Mental Health Team, they provide the input to care planning. As above, NIPS checks have shown that individuals who were on a SPAR/Care Plan when charged, were not necessarily on a SPAR/Care Plan

	when adjudicated on or when they entered the CSU. To say *"The outcome for these meant that they had already entered the CSU without assessment by healthcare professionals"* is incorrect.
4.36 [p55] *"Inspectors did not agree that prisoners who were on a SPAR should be segregated in a CSU."*	This is inaccurate. The context behind the cases quoted should be cited (observation cells are not just for people who are on a SPAR/SPAR Evo care plan). An observation cell is an observation cell irrespective of its location. This statement does not take into account the number of possible scenarios in which a person may be in a CSU e.g. a person, despite being on a SPAR, may have assaulted another person or have drugs concealed or displayed behaviours that could not be managed in a residential location. It also conflicts with HMIP Expectations which state "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." The inference being that they can be segregated.
4.37 [p55] description of medical markers	The text is misleading and inaccurate– not every prisoner who is held in the CSU has medical markers and, for example, 53% of prisoners have the medical marker applied "self-harm/history of self-harm" but the number of people who actively self-harm is lower. Medical markers are set a committal by healthcare, but are not always updated. There is no mental illness/mental issue marker, so nurses use the severe mental illness marker for any sort of mental health issue.
4.38 – 4.43 [p56, 57]	This is inaccurate. The text needs to be reviewed and redrafted in light of the published Review of Vulnerable Persons Detained in Northern Ireland Prisons [October 2021] (NIPS was given to understand that the two review teams would collaborate re CSUs)
4.39 [p56]– entire paragraph	This is inaccurate and misleading. They were not being held in CSU because they were awaiting a TDO – but rather their behaviours posed a risk to staff or prisoners, including themselves.
4.40 [page 56] *"The percentage of patients segregated in a CSU in Northern Ireland prior to their transfer was over twice as high as that in England (16% compared with 7%)."*	The prison population in England is substantially greater than Northern Ireland and this will therefore potentially skew the figures. What is the actual number of individuals within English prisons held in the CSU prior to transfer?

	The Review of Vulnerable People Detained in NI Prisons stated that *"The number of forensic secure beds in Northern Ireland falls significantly below equivalent bed numbers per capita in comparison to the rest of the UK; Shannon presently offers about one third of what is required."* It is inaccurate to present this figure, without the actual numbers and without the wider context.
4.42 [P56] *Data confirmed that in almost every case, patients held in Northern Ireland prisons had been transferred to hospital facilities in Northern Ireland.*	Does it mean that patients in a CSU who were awaiting a TDO were transferred to hospital facilities and that those hospital facilities were in NI and not elsewhere in the UK? This makes it sound that we use CSU as a holding facility for a TDO which is not accurate.
4.43 [P57] *The physical environments and facilities need to be modernised (particularly at Maghaberry and Ash House)*	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. The statement at 4.43 conflicts with the statement at 4.18
4.44 [P57] *...the Rule 32 reviews, oversight meetings and safer custody reviews still operated in parallel...* 4.45 [P57]*...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...*	This is inaccurate. These meetings are designed for different purposes These meetings are designed for different purposes. A person subject to Safety & Support review may be being managed because of issues that were totally divorced from the reasons they are on Rule 32 and may have been on the Safety & Support case load and scheduled for review prior to them being placed on Rule 32. The Rule 32 process will then follow a routine of Rule 32 review as and when required, along with weekly Oversight. Oversight is scheduled for each Tuesday and reviews everyone on Rule 32 at that time, irrespective of whether they are due to be reviewed and possibly extended the following day. This shows that careful consideration is being given to each individual and where one approach doesn't work or cannot be facilitated, we try something different – there are no set rules or silver bullets

	that will work for everyone
4.51 - 4.57 [p59]	This is inaccurate. The CCTV recordings will only tell one part of the story – the willingness for individuals to leave their cells for example cannot be assessed via CCTV and the absence of something being recorded on paper does not mean that it did or didn't happen. Staff cannot force someone to leave their cell if they do not wish to do so and there are examples of staff going to inordinate lengths to coax individuals out of their cell, including use of Donard and Reach gardens in Maghaberry, for example, as well as at HBW and Magilligan. The timing of the field-work for example was unfortunate as given the time of year and snow/very cold weather on some days, inspectors will not have witnessed a high level of desire to use the yards for example. The key word in para 4.57 is "chose"
4.58 [p 60] *"Inspectors concluded that many prisoners were being kept locked up for long periods each day]*	This is misleading. The words "kept locked up" are unfortunate as they imply that NIPS has deliberately completed this action – it does not reflect that choice that is referenced by the author in para 4.57 or of their right to make it. IT also ignores the lengths that NIPS and its partners have gone to provide activity, particularly during the pandemic. This para requires re-wording
4.65 [p61]– Entire Paragraph	This is a highly inaccurate paragraph, completely devoid of any evidence, but rather based on the anecdotal evidence and opinion of stakeholders. For such a paragraph to be included, which has the potential to destroy the morale and deeply affect staff who have recently been moved as a result of staff rotations, there must be a context and evidential standard applied to it. The paragraph is also at odds to the Vulnerable Prisoners Review which paid complimentary views towards staff.
4.72 [P63] *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.*	The considerable difference in the population breakdown across the three religious groups (other, Protestant and Catholics) has not been taken into account when referring to the awards of CC and is being taken out of context. In Hydebank Wood, there are almost three times the number of Catholic males to Protestant males and almost twice as many Catholic females to Protestant females. In fact, there are as many, if not more, Catholics than the

	other two religious groups combined. On that basis alone it is to be expected that in every aspect of life within Hydebank Wood, there would be a higher proportion of Catholics than any of the other religious groups. The embedded document below contains a full breakdown of statistics and analysis. Document2.docx

McVeigh, Meloney

From: [redacted]
Sent: 25 November 2021 15:35
To: [redacted]
Subject: RE: Official - Sensitive - A Review Into the Operation of CSU in NIPS factual accuracy response

Hi [redacted]
Ronnie has asked me to advise you that Belfast Met didn't provide Factual Accuracy comment through us. This reply was for NIPS only.
[redacted]

From: [redacted]
Sent: 25 November 2021 14:59
To: [redacted] <[redacted]@justice-ni.gov.uk>
Subject: RE: Official - Sensitive - A Review Into the Operation of CSU in NIPS factual accuracy response

Hi [redacted]

Can you confirm if this return also included point of factual accuracy from Belfast Metropolitan College?

Regards

[redacted]
Corporate Secretariat Officer

Criminal Justice Inspection
Block 1 Knockview Buildings
Stormont Estate
Belfast, BT4 3SJ

02890765764
[redacted]
[redacted]@cjini.org
You can follow CJI on Twitter @CJININews and the CJI YouTube channel.

From: [redacted] <[redacted]@justice-ni.gov.uk>
Sent: 19 November 2021 13:59
To: Durkin, Jacqui <Jacqui.Durkin@cjini.org>
Cc: [redacted]@cjini.org>; Armour, Ronnie <Ronnie.Armour@justice-ni.gov.uk>
Subject: Official - Sensitive - A Review Into the Operation of CSU in NIPS factual accuracy response

Good Afternoon Jacqui

Please see attached from Ronnie Armour. I would be grateful if you would acknowledge receipt.

Many thanks,
[redacted]

[redacted]
Ronnie Armour

Director General, Northern Ireland Prison Service &
Director, Reducing Offending

Northern Ireland Prison Service
028 9052 5[redacted] (ext [redacted])
[redacted]@justice-ni.gov.uk

3rd Floor, Dundonald House, Stormont Estate, Belfast BT4 3SU

Criminal Justice Inspection
Northern Ireland
a better justice system for all

21 December 2021

Mr Ronnie Armour
Director General
Northern Ireland Prison Service
Room 317
Dundonald House
Upper Newtownards Road
BELFAST
BT4 3SU

By email

Dear Ronnie

A Review of Care and Supervision Units in the Northern Ireland Prison Service – draft report for factual accuracy check

Thank you for your letter and detailed attachments of 18 November in response to my request for a factual accuracy check on the above draft report. I appreciate the extra attention you have given to this draft report and welcome your commitment to continuous improvement.

I think the context for this Review could be more accurately described as stated in the Minister of Justice's (MoJ's) letter to me requesting it, that is, significant concerns being raised about the operation of Care and Supervision Units (CSUs) and prisoners being held in solitary confinement. Regardless of the number, I expect you would agree that any number of such allegations are a concern and resulted in the request for a Review during the Covid-19 pandemic (the pandemic) that required a response to commence in a reasonable timescale given the nature of the concerns.

At the outset, I think it is important to state, and as you well know from previous inspections, that the factual accuracy process allows the organisation under review or inspection to challenge statistics and inaccurate terminology or references – it does not enable an organisation to challenge our judgements unless they are clearly based on inaccurate data. Most of your comments or proposed changes are an attempt to emphasise and detail context, modify judgements based on evidence and rewrite our report which is unacceptable and could be perceived as an attempt to interfere with CJI's independence and impartiality. In some instances the tone and content is neither helpful nor respectful. I am sure this is not what you intended.

I can also assure you that the Inspection Team and I were and are acutely aware of the impact of the pandemic on all those we inspect, including Northern Ireland Prison Service staff and the services they provide as well as prisoners. I appreciate

the successful efforts to prevent Covid infections in the wider prison population and how you have deployed additional resources to mitigate risks, manage regimes and maximise your staff resources. I believe this has been appropriately reflected in the draft report. However, the pandemic did not set aside or pause Human Rights obligations or the Minimum Standards for the Treatment of Prisoners in Northern Ireland held in the CSUs. Prisoners in the CSU may already have spent 14 days in isolation and the absence of contacts other than Prison Officers and health care staff meant CSU staff were the key providers of or attempts to provide meaningful human contact during this period, and providing adequate evidence that it had been provided or attempted, at a time when the CSU population was lower and CSU staff were not required for adjudication hearings. I would encourage you to consider the evidence presented in this report rather than rely on the impact of the pandemic across the whole prison estate and the severe complexities of some of the people in your care as reasons for the regime experienced by some.

The experiences of prisoners during the pandemic have been publicly commented on by the National Preventative Mechanism and Charlie Taylor, Chief Inspector of Prisons in England and Wales among others. The need for adequate evidence and assurances that Standards are being met or evidence of attempts to meet them were and are required before, during and after the pandemic. With this in mind, I was particularly concerned about the lack of focus on the people in your care in your response and their outcomes rather than defensive comments suggesting there was insufficient context and prisoner and other stakeholder comments were given undue weight and too much prominence in this report. The Inspection Team and I are well aware of the need to consider and balance such evidence and I can assure you where such comments are used they are appropriate and fairly reflect the evidence gathered and assessed.

As you know, the MoJ requested this review and the Terms of Reference were shared for comment. These set out the clear intention to carry out a focused review on the operation of Care and Supervision Units using Her Majesty's Inspectorate of Prisons (HMIP) Healthy Prison Tests and Expectations. Attempts to compare this review with past unannounced establishment inspections covering all aspects of a prison over four days are neither helpful nor relevant. The scope and extent for evidence gathering for this review, as detailed in the draft report, was much wider and deeper than that for unannounced full prison inspections and carried on for some time beyond on site fieldwork. However, where they are similar is that they both provide assessments based on evidence and they are both focused on prisoner outcomes.

Your comments regarding HMIP application of their standards to places of segregation in prisons in England and Wales are best answered by Charlie Taylor, therefore, I would be grateful if you indicated if you wish your letter and this response to be forwarded to him for consideration.

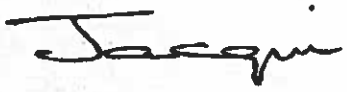
I think it is also important to note that feedback meetings were held with Governors at the end of on site fieldwork and any immediate concerns raised. As stated in the report, evidence gathering and analysis extended far beyond the Inspection Team's on site presence. You will also recall that concerns raised about an individual prisoner during the inspection were raised immediately with the relevant Governor and you advised me of the action being taken in response.

Notwithstanding, the Inspection Team and I have carefully considered each comment made and where appropriate have indicated any changes made to the draft report in the required format for responses. As we discussed, I believe strategic recommendation two was misinterpreted and it was never the intention that the MoJ would provide or fund services that fall to the Department of Health but rather could provide an opportunity to highlight the issues, impact and resources required by the Northern Ireland Prison Service to mitigate the absence of an appropriate health response and the MoJ could be presented with options for further discussion with the Minister of Health. I hope the rewording of this recommendation, agreed with the Regulation and Quality Improvement Authority Inspectors, is helpful. I have also reflected on feedback and concerns regarding the Executive Summary and have added some text previously contained in my draft foreword. As I explained previously, the Executive Summary is not intended to be a distilled version of the entire report but to highlight the key findings and recommendations. I appreciate that when the report is sent to the Minister for approval to publish you will then have sight of my draft foreword.

As stated above, I welcome your commitment to continued improvement as a priority and would appreciate if you could provide, in the usual format, confirmation of the recommendations you are accepting and an action plan to implement them. I have noted the actions you have taken to date and am considering how best to review recommendation implementation in the future.

Finally, I will now proceed to seek the Minister's permission to publish this report in the New Year and, as usual, will share my draft Press Release and keep your office informed of a confirmed publication date.

Yours sincerely



Jacqui Durkin
Chief Inspector of Criminal Justice in Northern Ireland

Encs

Director of Reducing Offending &
Director General, Northern Ireland Prison Service

Department of
Justice
An Roinn Dlí agus Cirt
Mànnystrie O tha Laa
www.justice-ni.gov.uk

Room 317, Dundonald House
Upper Newtownards Road
Belfast BT4 3SU
Tel: 028 9052 5219
Email: ronnie.armour@justice-ni.gov.uk

Jacqui Durkin
Chief Inspector
Criminal Justice Inspection NI
Block 1, Knockview Buildings
Stormont Estate
Belfast BT1 3SJ

7 January 2022

Dear Jacqui

A REVIEW OF CARE AND SUPERVISION UNITS IN THE NORTHERN IRELAND PRISON SERVICE – A DRAFT REPORT FOR FACTUAL ACCURACY CHECK:

Thank you for your letter dated 21 December and for taking the time to consider my earlier correspondence of 18 November which enclosed our factual accuracy comments on the above draft report.

I was concerned to read the third paragraph of your letter and want to take this opportunity to assure you that I value the importance of independent scrutiny and the role CJI has played in driving continuous improvement across the justice system.

The purpose of my letter was not to be unhelpful or disrespectful, nor was it to dispute your findings, indeed I acknowledged in my letter that the report will make a significant contribution to the delivery and operation of CSUs in our three prisons. To that end we have already made significant efforts to address a number of the areas of concern you highlighted and we will continue to do so.

I want to be very clear that it was never my intention, as I said in my previous letter, to deflect away from justified evidence based criticism. However, I do think it is important that justice leaders should be able to offer comments and context and seek clarification on the draft reports you write and that this process should help to ensure robust outcomes rather than diminish from them.

Scrutiny reports are hugely important and often have far reaching implications. Consequently, provided comments are offered in a constructive and transparent way that recognises that final decisions on the content of reports and recommendations made are for you and you alone to make, I do not believe this in any way questions the independence of your office.

Department of
Justice
An Roinn Dlí agus Cirt
Männystrie O tha Laa
www.justice-ni.gov.uk

I regret if my previous letter caused any concern in this regard and I hope you will accept that it was not my intention to do so.

Yours sincerely,

RONNIE ARMOUR
Director General

McVeigh, Meloney

From: McVeigh, Meloney
Sent: 20 January 2022 11:29
To: [redacted]@justice-ni.gov.uk
Subject: CSU Recommendations

Importance: High

Morning [redacted] and [redacted],

We received the MoJ's permission to publish CSU yesterday afternoon which I presume you both know already. Can I check and confirm if all the CSU review recommendations are being accepted by NIPS? I'd like to incorporate this as a positive point positive point in the PR if its correct.

Grateful if you could confirm either way asap.

Thanks Meloney

Meloney McVeigh
Business and Communications Manager

Criminal Justice Inspection Northern Ireland
Block 1, Knockview Buildings,
Stormont Estate, Belfast, BT4 3SJ

Tel: 02890 765742 (Direct Line) or x 89742
02890 765764 (Switch Board)
Mobile: 0772 5581835
E-mail: Meloney.McVeigh@cjini.org

You can follow CJI on Twitter @CJININews and the CJI YouTube channel.

McVeigh, Meloney

From: McVeigh, Meloney
Sent: 20 January 2022 13:14
To: [redacted]@justice-ni.gov.uk
Subject: FW: CSU Recommendations

[redacted],

Jacqui has written to the Minister today advising of a slight change to the wording of op rec 1 in the CSU review report which has been requested by RQIA following late discussions with the SE Trust. I understand Ronnie was verbally made aware yesterday.

Jacqui has also advised our intention to move to publish on 1 February 2022 (Tues week).

I'll keep in touch.

Meloney

From: McVeigh, Meloney
Sent: 20 January 2022 11:31
To: [redacted]@justice-ni.gov.uk>; [redacted]@justice-ni.gov.uk>
Subject: RE: CSU Recommendations

I'll come back you both on that as soon as I can.

Meloney

From: [redacted]@justice-ni.gov.uk>
Sent: 20 January 2022 11:30
To: McVeigh, Meloney <meloney.mcveigh@cjini.org>; [redacted]@justice-ni.gov.uk>
Subject: RE: CSU Recommendations

Ill come back to you – any idea on dates you are working to?

[redacted]

From: McVeigh, Meloney
Sent: 20 January 2022 11:29
To: [redacted]@justice-ni.gov.uk>; [redacted]@justice-ni.gov.uk>
Subject: CSU Recommendations
Importance: High

Morning [redacted] and [redacted],

We received the MoJ's permission to publish CSU yesterday afternoon which I presume you both know already. Can I check and confirm if all the CSU review recommendations are being accepted by NIPS? I'd like to incorporate this as a positive point positive point in the PR if its correct.

Grateful if you could confirm either way asap.

Thanks Meloney

Meloney McVeigh
Business and Communications Manager

Criminal Justice Inspection Northern Ireland
Block 1, Knockview Buildings,
Stormont Estate, Belfast, BT4 3SJ

Tel: 02890 765742 (Direct Line) or x 89742
02890 765764 (Switch Board)
Mobile: 0772 5581835
E-mail: Meloney.McVeigh@cjini.org

You can follow CJI on Twitter @CJININews and the CJI YouTube channel.

McVeigh, Meloney

From: McVeigh, Meloney
Sent: 20 January 2022 13:10
To: [redacted]
Subject: RE: Letter to Minister of Justice from J Durkin re Care and Supervision Review Report

Lovely [redacted] – many thanks.

Meloney

From: [redacted] <[redacted]@justice-ni.gov.uk>
Sent: 20 January 2022 13:08
To: McVeigh, Meloney <meloney.mcveigh@cjini.org>
Subject: RE: Letter to Minister of Justice from J Durkin re Care and Supervision Review Report

Good Afternoon Meloney
I am acknowledging receipt on behalf of Ronnie.

Thank you
[redacted]

From: McVeigh, Meloney
Sent: 20 January 2022 13:06
To: DOJ Minister's Office <DOJ.MinistersOffice@justice-ni.gov.uk>
Cc: [redacted] <[redacted]@justice-ni.gov.uk>; [redacted] <[redacted]@justice-ni.gov.uk>; May, Peter <peter.may@justice-ni.gov.uk>; Armour, Ronnie <Ronnie.Armour@justice-ni.gov.uk>; [redacted] <[redacted]@rqia.org.uk>; [redacted] <[redacted]@justice-ni.gov.uk>; Durkin, Jacqui <Jacqui.Durkin@cjini.org>; [redacted] <[redacted]@cjini.org>; [redacted] <[redacted]@justice-ni.gov.uk>
Subject: Letter to Minister of Justice from J Durkin re Care and Supervision Review Report
Importance: High

Good afternoon,

Please find attached a letter from Jacqui Durkin, Chief Inspector of Criminal Justice in Northern Ireland for the attention of the Minister of Justice regarding an amendment to an operational recommendation within the Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service (Review report).

I would be grateful if the content of this letter could be brought to the Minister's attention at the earliest opportunity its receipt confirmed at your convenience.

Should the Minister have any queries or questions, please do not hesitate to contact the Chief Inspector or myself directly.

Thank you for your prompt attention.

Kind regards,
Meloney

Meloney McVeigh
Business and Communications Manager

Criminal Justice Inspection Northern Ireland
Block 1, Knockview Buildings,
Stormont Estate, Belfast, BT4 3SJ

Tel: 02890 765742 (Direct Line) or x 89742
02890 765764 (Switch Board)
Mobile: 0772 5581835
E-mail: Meloney.McVeigh@cjini.org

You can follow CJI on Twitter @CJININews and the CJI YouTube channel.

McVeigh, Meloney

From: McVeigh, Meloney
Sent: 21 January 2022 10:23
To: [redacted]
Cc: [redacted]
Subject: RE: CSU Recommendations

Thanks for the update[redacted].
Speak soon

Meloney

From: [redacted]@justice-ni.gov.uk>
Sent: 21 January 2022 10:16
To: McVeigh, Meloney <meloney.mcveigh@cjini.org>
Cc: [redacted]@justice-ni.gov.uk>
Subject: RE: CSU Recommendations

Morning.

Ronnie will be writing to Jacqui today setting out our position.

Perhaps we can get a chat after she has had time to consider.

[redacted]

From: McVeigh, Meloney
Sent: 21 January 2022 10:02
To: [redacted]@justice-ni.gov.uk>
Cc: [redacted]@justice-ni.gov.uk>
Subject: RE: CSU Recommendations

Hi [redacted],
Can you confirm if NIPS are accepting all CSU recs yet?
Thanks

Meloney

From: [redacted]@justice-ni.gov.uk>
Sent: 20 January 2022 11:30
To: McVeigh, Meloney <meloney.mcveigh@cjini.org>; [redacted]@justice-ni.gov.uk>
Subject: RE: CSU Recommendations

Ill come back to you – any idea on dates you are working to?

[redacted]

From: McVeigh, Meloney
Sent: 20 January 2022 11:29
To: [redacted]@justice-ni.gov.uk>;[redacted]@justice-ni.gov.uk>

Subject: CSU Recommendations
Importance: High

Morning [redacted] and [redacted],

We received the MoJ's permission to publish CSU yesterday afternoon which I presume you both know already. Can I check and confirm if all the CSU review recommendations are being accepted by NIPS? I'd like to incorporate this as a positive point positive point in the PR if its correct.

Grateful if you could confirm either way asap.

Thanks Meloney

Meloney McVeigh
Business and Communications Manager

Criminal Justice Inspection Northern Ireland
Block 1, Knockview Buildings,
Stormont Estate, Belfast, BT4 3SJ

Tel: 02890 765742 (Direct Line) or x 89742
02890 765764 (Switch Board)
Mobile: 0772 5581835
E-mail: Meloney.McVeigh@cjini.org

You can follow CJI on Twitter @CJININews and the CJI YouTube channel.

McVeigh, Meloney

From: McVeigh, Meloney
Sent: 21 January 2022 11:37
To: [redacted]
Subject: RE: RA to Jacqui Durkin re CJINI Review into CSU in NIPS 210122

[redacted],
Thanks for sharing. I will reflect the acceptance of the recs in our PR. Grateful if you could let Ronnie know I will share a updated designed copy of the review report as soon as possible. I expect to be able to do this next week.

Meloney

From: [redacted] <[redacted]@justice-ni.gov.uk>
Sent: 21 January 2022 11:23
To: McVeigh, Meloney <meloney.mcveigh@cjini.org>
Subject: FW: RA to Jacqui Durkin re CJINI Review into CSU in NIPS 210122

As previous.

[redacted]

From: [redacted]
Sent: 21 January 2022 11:18
To: Durkin, Jacqui <Jacqui.Durkin@cjini.org>
Cc: [redacted] <[redacted]@cjini.org>; Armour, Ronnie <Ronnie.Armour@justice-ni.gov.uk>
Subject: RA to Jacqui Durkin re CJINI Review into CSU in NIPS 210122

Good Morning Jacqui

Please see attached from Ronnie.

Kind regards,

[redacted]

[redacted]Ronnie Armour
Director General, Northern Ireland Prison Service &
Director, Reducing Offending

Northern Ireland Prison Service
028 9052 5[redacted] (ext [redacted]
[redacted]@justice-ni.gov.uk

3rd Floor, Dundonald House, Stormont Estate, Belfast BT4 3SU

McVeigh, Meloney

From: McVeigh, Meloney
Sent: 21 January 2022 12:05
To: [redacted]
Subject: RE: CSU PR & Publication

[redacted]/[redacted],
A draft PR is currently with our inspection partners. I will share after it has been agreed at this end. I'll pick up the discussion re plans next week.
Hope you both have a good weekend.

Meloney

From: [redacted] <[redacted]@justice-ni.gov.uk>
Sent: 21 January 2022 11:47
To: McVeigh, Meloney <meloney.mcveigh@cjini.org>
Subject: RE: RA to Jacqui Durkin re CJINI Review into CSU in NIPS 210122

Thanks – will do.

When do you think you'll have your PR – and when do you plan to issue under embargo etc?

[redacted]

From: McVeigh, Meloney
Sent: 21 January 2022 11:37
To: [redacted] <[redacted]@justice-ni.gov.uk>
Subject: RE: RA to Jacqui Durkin re CJINI Review into CSU in NIPS 210122

[redacted]
Thanks for sharing. I will reflect the acceptance of the recs in our PR. Grateful if you could let Ronnie know I will share a updated designed copy of the review report as soon as possible. I expect to be able to do this next week.

Meloney

From: [redacted] <[redacted]@justice-ni.gov.uk>
Sent: 21 January 2022 11:23
To: McVeigh, Meloney <meloney.mcveigh@cjini.org>
Subject: FW: RA to Jacqui Durkin re CJINI Review into CSU in NIPS 210122

As previous.

[redacted]

From: [redacted]
Sent: 21 January 2022 11:18
To: Durkin, Jacqui <Jacqui.Durkin@cjini.org>
Cc: [redacted]@cjini.org>; Armour, Ronnie <Ronnie.Armour@justice-ni.gov.uk>
Subject: RA to Jacqui Durkin re CJINI Review into CSU in NIPS 210122

Good Morning Jacqui

Please see attached from Ronnie.

Kind regards,

[redacted]

[redacted]/Ronnie Armour
Director General, Northern Ireland Prison Service &
Director, Reducing Offending

Northern Ireland Prison Service
028 9052 5[redacted] (ext [redacted]
[redacted]@justice-ni.gov.uk

3rd Floor, Dundonald House, Stormont Estate, Belfast BT4 3SU

Criminal Justice Inspection
Northern Ireland
a better justice system for all

27 January 2022

Mr Ronnie Armour
Director General
Northern Ireland Prison Service
Room 317
Dundonald House
Upper Newtownards Road
BELFAST
BT4 3SU

By email

Dear Ronnie

Review into the operation of Care and Supervision Units in the Northern Ireland Prison Service (the Review)

Thank you for your letter dated 21 January 2022 confirming acceptance of the Review report recommendations relevant to the Northern Ireland Prison Service (NIPS) and advising of the establishment of a Steering Group. I look forward to receiving a copy of the action plan.

I have attached a final copy of the Review report as requested.

I have noted your comment about the Minister's view on Recommendation 2. As you know, I remain of the view that the NIPS, as part of further developing their partnership approach with the South Eastern Health and Social Care Trust (the Trust), are best placed to inform and advise the Trust and others about the impact the current arrangements have on the NIPS and their care and treatment of prisoners with severe mental disorders. The provision and funding of alternative mental health services are of course a matter for the Trust, the Health and Social Care Board and the Department of Health.

I agree it would be helpful to meet in three months to discuss progress and will contact your office to make arrangements.

Yours sincerely

Jacqui

Jacqui Durkin
Chief Inspector of Criminal Justice in Northern Ireland

Enc

McVeigh, Meloney

From: McVeigh, Meloney
Sent: 27 January 2022 14:13
To: [redacted]@justice-ni.gov.uk
Subject: CSU Report
Attachments: CJI - CSU Report - Draft 8 27.01.22.pdf

[redacted]

Please find attached a copy of the final version of the CSU report. Please note this version is not include web accessibility functionality as I am still to receive this from our graphic designers.

Jacqui has sent a copy directly to Ronnie with other correspondence.

Many thanks Meloney

Meloney McVeigh
Business and Communications Manager

Criminal Justice Inspection Northern Ireland
Block 1, Knockview Buildings,
Stormont Estate, Belfast, BT4 3SJ

Tel: 02890 765742 (Direct Line) or x 89742
02890 765764 (Switch Board)
Mobile: 0772 5581835
E-mail: Meloney.McVeigh@cjini.org

You can follow CJI on Twitter @CJININews and the CJI YouTube channel.

McVeigh, Meloney

From: McVeigh, Meloney
Sent: 27 January 2022 17:22
To: [redacted], [redacted]
Subject: CSU - Final report and release
Attachments: EXEC MEDIA RELEASE -CSU FINAL 27.01.22.docx; CJI - CSU Report -FINAL Tagged 27.01.22.pdf

Importance: High

Hi [redacted]
I've attached final copies of the CSU report and pr for your info and [redacted]
A copy of the report was send this afternoon by Jacqui to Ronnie. This copy incorporates the amended wording to two recommendations that the Minister was made aware of by Jacqui that were not incorporated in the initial word version of the report she received when permission to publish was requested at the start of the month.

Many thanks
Meloney

Meloney McVeigh
Business and Communications Manager

Criminal Justice Inspection Northern Ireland
Block 1, Knockview Buildings,
Stormont Estate, Belfast, BT4 3SJ

Tel: 02890 765742 (Direct Line) or x 89742
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Mobile: 0772 5581835
E-mail: Meloney.McVeigh@cjini.org

You can follow CJI on Twitter @CJININews and the CJI YouTube channel.

Criminal Justice Inspection
Northern Ireland
a better justice system for all

PRESS RELEASE

Strictly under embargo until 0100hrs, 1 February 2022

Independent review finds some prisoners in Care and Supervision Units experiencing regimes amounting to solitary confinement

An independent review of the operation of Care and Supervision Units in the Northern Ireland Prison Service (NIPS) led by Criminal Justice Inspection Northern Ireland (CJI) has found some prisoners held there experienced regimes which amounted to solitary confinement and their treatment did not meet the expected United Nations (UN) Standard Minimum Rules.

The Chief Inspector of Criminal Justice in Northern Ireland, Jacqui Durkin agreed to undertake the focused review following a request from the Minister of Justice in November 2020 after significant concerns were raised with the Minister about the operation of the units in Northern Ireland's prisons. It was carried out in partnership with Inspectors from the Regulation and Quality Improvement Authority and the Education and Training Inspectorate.

"Prisoners can be segregated in Care and Supervision Units (CSUs) away from the general prison population for their own safety or the safety of others, for breaking Prison Rules or because they are suspected of having drugs or other illicit items in their possession. Some prisoners placed in the CSUs have severe mental disorders and individual needs that make them more vulnerable, complex and particularly challenging for staff to care for," said Ms Durkin.

"However regardless of why any male or female prisoner is segregated in a CSU, there are accepted *Expectations* developed by Her Majesty's Inspectorate of Prisons in England and Wales (HMIP) and UN Standard Minimum Rules for their treatment and care that apply, which include access to health care and purposeful activity, like learning, skills and physical activity.

"This in-depth review found evidence that the regime experienced by a number of CSU prisoners did not meet the UN Standard Minimum Rules known as the *Mandela Rules*. We found evidence that prisoners in CSUs were spending too long in their cell without meaningful human contact," said the Chief Inspector.

She continued: "During our work Inspectors met impressive and committed Prison Officers and health care staff in CSUs who demonstrated compassion for the prisoners and patients in their care while facing complex challenges every day and I commend them all for their efforts.

"But I believe that without appropriate evidence, it is not possible to provide satisfactory assurance to prisoners and their families, the Minister of Justice, the Northern Ireland Assembly or the wider community, that prisoners held in CSUs in Northern Ireland's prisons experienced a regime that met required minimum standards for the treatment of prisoners," said Ms Durkin.

Inspectors found meaningful human contact and interactions with prisoners were not sufficiently evidenced or recorded to dispel wider concerns about the length of time prisoners spent in their cells.

"For contact to be 'meaningful' it must extend beyond meeting a prisoner's basic needs such as providing a food tray at a door, asking if they had any requests or wanted a shower," said Ms Durkin.

"Establishing and maintaining meaningful human contact with prisoners who do not, or cannot, engage can be extremely challenging. It requires skilled, motivated staff with access to support and specialist advice when needed."

Inspectors found opportunities for prisoners held in the CSUs to participate in purposeful activity, including learning and skills and physical activity, were not proactively encouraged and association with other prisoners was not routinely assessed or provided.

Staff were hindered by the limitations of the present facilities and the Inspection Team identified a clear need for Prison Officers to be supported with appropriate staff selection procedures and training to improve prisoner outcomes.

Ms Durkin said that despite the NIPS's promotion of a corporate ethos of prisoners being treated as *'people in our care,'* it did not have a strategy in place for the operation and future development of CSUs where some of the most vulnerable people in the prison system live.

"The lack of a clearly defined corporate approach for CSUs – that is promoted by the NIPS leadership and supports the implementation and delivery of consistent, operational practice in each CSU - has hampered opportunities to improve outcomes for segregated prisoners," said the Chief Inspector.

Inspectors also found the shared CSU for young men and women at Hydebank Wood in place at the time of fieldwork was undertaken was out of step with the UN *Mandela Rules* and HMIP's specific *Expectations* for women in prison as it did not provide 'entirely separate' facilities.

Inspectors have made three strategic and 11 operational recommendations for improvement as a result of their findings.

"I believe these recommendations will help ensure UN Standard Minimum Rules for the treatment and care of segregated prisoners are met and deliver improvements in oversight and operational prison practice, health care provision, education and training opportunities and outcomes for prisoners" said Ms Durkin.

"I acknowledge the messages in the review report are hard for many involved in the care of prisoners to hear, particularly given the efforts made by the NIPS to keep prisoners safe from the COVID-19 virus during the pandemic and the focus there has been on managing its impact on staff and services. However, the issues we identified existed before, were present during and will extend beyond the pandemic unless action is taken on the recommendations," said Ms Durkin.

"I am pleased the NIPS has accepted the review report recommendations and I expect the Director General and his leadership team, working with the Department of Justice, and its partners in the South Eastern Health and Social Care Trust and Belfast Metropolitan College, will specifically reflect them in its future plans and priorities to improve prisoner outcomes.

"I will be maintaining a focus on the issues identified in this review report when we follow-up on the implementation of the recommendations as part of future prison inspections we undertake with our Inspection partners," concluded the Chief Inspector.

ENDS

Notes for editors

- An advance copy of the Review Report into the Operation of CSUs by the NIPS can be viewed by following the link INSERT LINK. Following the publication, the review report can be viewed or downloaded from the CJI website.
- On-site fieldwork within each of Northern Ireland's three CSUs took place over a three-week period in January and February 2021.
- As part of the in-depth review, Inspectors examined policies and procedures relating to the operation of the CSUs, paper and electronic records, journals, CCTV and body-worn camera footage and spoke with staff at all levels within the NIPS and Prison Officers and health care staff at working in the CSUs.

Inspectors also spoke to prisoners held in the CSU at the time of the inspection fieldwork and those who previously held in a CSU about their treatment and experience. Inspectors also engaged with stakeholders from the voluntary and community sector.

- A review of the draft report was undertaken by Inspectors from Her Majesty's Inspectorate of Prisons in England and Wales.
- Rule 44 of the UN Standard Minimum Rules (Mandela Rules) defines solitary confinement as: "*The confinement of prisoners for 22 hours or more a day without meaningful human contact.*"
- Analysis of a sample of CCTV footage from each CSU facility viewed by Inspectors showed the average time spent out of cell for CSU prisoners in Maghaberry over a five-day period was 25 minutes per day; at Magilligan over a three-day period it was 26 minutes per day and at Hydebank over a three-day period it was 89 minutes per day.
- **For further information or to obtain an interview with the Chief Inspector of Criminal Justice, Jacqui Durkin, please contact Meloney McVeigh, Communications Manager on 0772 558 1835.**

Notes ends

Director of Reducing Offending &
Director General, Northern Ireland Prison Service

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Jacqui Durkin
Chief Inspector
Criminal Justice Inspection NI
Block 1, Knockview Buildings
Stormont Estate
Belfast BT4 3SJ

21 January 2022

Dear Jacqui,

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

I am writing to confirm the Northern Ireland Prison Service (NIPS) position in relation to the three strategic and nine operational recommendations relevant to NIPS contained in the CJINI Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service. It is my intention to share with you our action plan following a meeting of the Steering Group I have established to oversee implementation of the recommendations planned for next week.

Regarding the amendments you have made in recent days, perhaps your office would send me a final version of the Review ahead of publication.

Strategic Recommendations:

Recommendation 1 – Accepted. This is a detailed recommendation but I am confident that we will be able to deliver the required outcomes by 31 October 2022. It is my intention in developing the framework to engage with the NI Human Right Commission in an effort to ensure minimum standards are reflected. I have already indicated to the Chief Commissioner that I wish to discuss this recommendation with her following publication of your report.

While I accept the rationale behind the need for a process to select, train and support staff working in our CSU, I remain concerned that anticipated staffing constraints and financial pressures could make the selection and subsequent deployment of selected and appropriately trained staff difficult to achieve. I am also concerned that the rationale that requires a selection process for staff working in CSU could also be made for other business areas within our prisons.

Revised Recommendation 2 – Accepted. Whilst the revision you made to this recommendation means that NIPS can now accept it, the Minister remains of the view that this is a recommendation that should have been directed to the Health Minister. NIPS is committed to working with Health colleagues to implement the recommendation but we need to be clear that without support from and action by the

Department of Health and the South Eastern Trust the required outcome will not be achieved.

Recommendation 3 – Accepted. NIPS is committed to working with Belfast Metropolitan Collage to achieve this recommendation within the timeframe set.

Operational Recommendations:

Revised Recommendation 1 – Accepted. As the revised recommendation is now in line with Mandela Rule 46 we are now content with it. NIPS will ensure that the South Eastern Trust is given the opportunity to undertake the necessary assessments following the placement of individuals in our CSUs. The timescale established is six months but we will facilitate such involvement with immediate effect.

Recommendation 2 – Accepted. We will implement this recommendation within the timescale set, although it might have been better to await the implementation of Strategic Recommendation 1.

Recommendation 3 – Accepted.

Recommendation 4 – Accepted.

Recommendation 5 – Accepted. NIPS will be limited is what can be achieved in this area but we are committed to do the best we can within the constraints that we are working.

Recommendation 6 – Accepted.

Recommendation 7 – Accepted

Recommendations 8 – Accepted.

Recommendation 11 – Accepted. The female CSU at Hydebank Wood is no longer in the same building as the male CSU. As an interim measure the female CSU was transferred back to Ash House within 48 hours of receipt of your draft report. A new dedicated landing for the female CSU will be opened elsewhere within the prison complex within the next few weeks. Subject to your view, we believe the implementation of this recommendation is now complete.

In terms of governance I will chair a Steering Group comprising NIPS, SET and when appropriate Belfast Metropolitan Collage staff to oversee the implementation of your recommendations. Notwithstanding the discussions we have had about this report, our commitment to make our CSUs the best they can be is resolute and as I have previously said your recommendations will help us to do that.

Department of
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In closing, I think it would be helpful for us to meet, in say three months, to review the progress we are making. It is our intention, notwithstanding the many other challenges we currently face, to demonstrate significant progress as quickly as possible.

Yours sincerely,

RONNIE ARMOUR
Director General

A Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service

Date

Laid before the Northern Ireland Assembly under Section 49(2) of the Justice (Northern Ireland) Act 2002 (as amended by paragraph 7(2) of Schedule 13 to The Northern Ireland Act 1998 (Devolution of Policing and Justice Functions) Order 2010) by the Department of Justice.

Criminal Justice Inspection Northern Ireland
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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)
DfE	Department for the Economy
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	Supporting Prisoners at Risk
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.

Chief Inspector's Foreword

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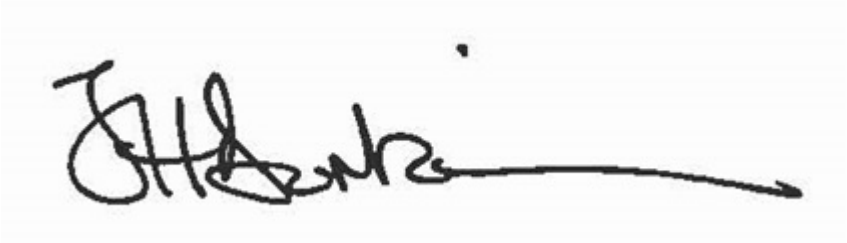

Jacqui Durkin
Chief Inspector of Criminal Justice in Northern Ireland
????date

Criminal Justice Inspection Northern Ireland
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Executive Summary

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 *"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 HMIP '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 CSU.

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. 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 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 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

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 Units 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 (*paragraphs 2.8*).

2. The Northern Ireland Prison Service in partnership with the South Eastern Health and Social Care Trust and their governing Departments should urgently review current arrangements to ensure that prisoners suffering from severe mental disorders (including personality disorders ,dementia and intellectual disabilities) are cared for and treated in a secure inpatient mental health hospital, suitably equipped and with sufficiently qualified staff to provide them with the necessary assistance. A joint feasibility paper with costed options should be submitted to the Minister of Justice within three months of publication of this report *(paragraph 4.42)*.

3. Within six months of the publication of this report, the Northern Ireland Prison Service, in partnership with Belfast Metropolitan College, 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 4.67*).

Operational recommendations

1. The Northern Ireland Prison Service and South Eastern Health and Social Care Trust should ensure that all prisoners are assessed by health care staff prior to a decision being taken to 'award' cellular confinement. This should be implemented within six months of the publication of this report *(paragraph 2.14)*.

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*).

3. The Northern Ireland Prison Service should ensure all Care and Supervision Units have a clearly designated sluice room for the safe disposal of bodily waste. Sluice rooms should be 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*).

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 their publication of this report (*paragraph 3.11*).

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*).

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 3.62)*.

7. The Northern Ireland Prison Service in partnership with Belfast Metropolitan College 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 3.63)*.

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 3.71)*.

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 3.74)*.

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 3.86)*.

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).

Scope and methodology

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

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

- 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.

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[2] 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 segregation of prisoners in CSUs, this report also considered arrangements for woman 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.

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 separate prisoners held at the four prisons were Rule 32(1), Rule 35(4) and Rule 39(1) (f).[3]

[2] 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).
[3] *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*

- **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[4], 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.

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.*'[5]

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. [6]

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:[7]

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[4] *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.*

[5] *United Nations Office on Drugs and Crime, The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)* 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.

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

[7] *Penal Reform International, Essex paper 3, Initial guidance on the interpretation and implementation*

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.

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).[8] 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;

of the UN Nelson Mandela Rules, February 2017 available at https://cdn.penalreform.org/wp-content/uploads/2016/10/Essex-3-paper.pdf

[8] *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

- 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.

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 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 are 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-centred 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 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 CSU. Data was not available on how the changed procedure resulted in better or poorer outcomes for prisoners.

OPERATIONAL RECOMMENDATION 1

The Northern Ireland Prison Service and South Eastern Health and Social Care Trust should ensure that all prisoners are assessed by health care staff prior to a decision being taken to 'award' cellular confinement. 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 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 coordinated 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.

Care and Supervision Units 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 4 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 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 requires effective governance arrangements.

Photograph 1	**Photograph 2**
	
Trolleys in use at Maghaberry	***Trolleys in use at Maghaberry***
Photograph 3	**Photograph 4**
	
Storeroom sluice sink at Maghaberry	***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

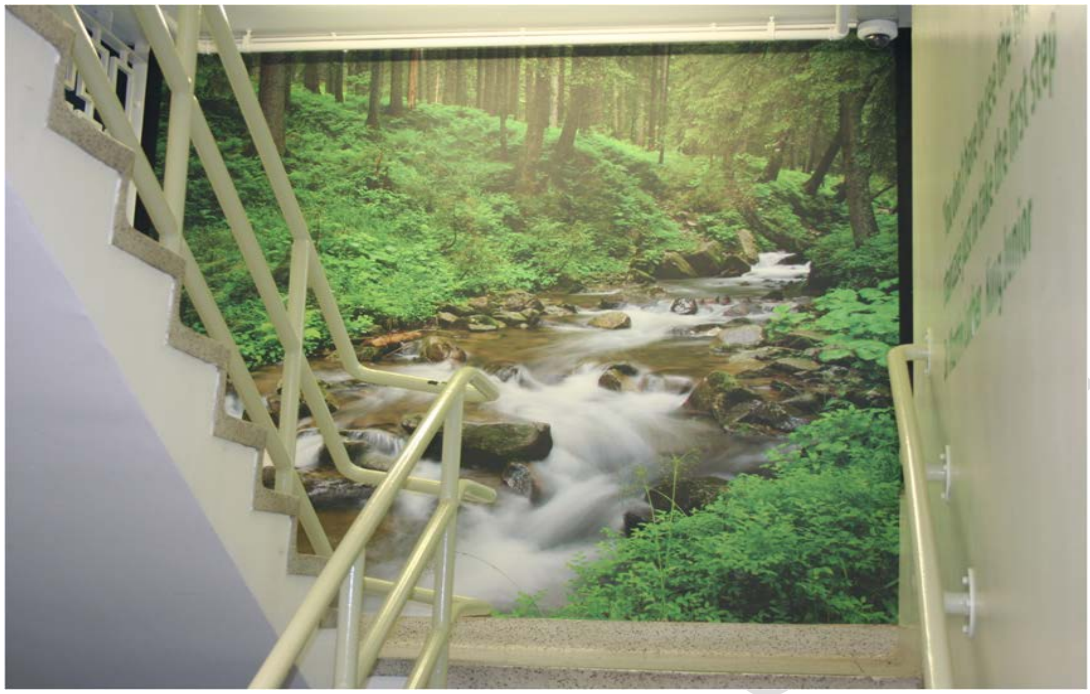
3.8 The CSU at Hydebank had opened during 2019. A recent unannounced full inspection by CJI and partners had acknowledged the significant improvements and important changes in approach being provided by a new CSU facility.[9] The CSU was a bright, vibrant and a calming place. There was good use of colour and acoustics. The standard of cleanliness was evident throughout the unit. There was no designated sluice room for disposing of urine when special accommodation was in use for drug recovery and staff were using a toilet that did not support good infection control practices. This is not acceptable and alternative arrangements need to be put in place to dispose of urine.

OPERATIONAL RECOMMENDATION 3

The Northern Ireland Prison Service should ensure that all Care and Supervision Units have a clearly designated sluice room for the safe disposal of bodily waste. Sluice rooms should be 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.

[9] *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 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 and observation cells for those deemed at risk of self-harm and others 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.

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 is to 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 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)*

Picture 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 i 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 for the period 2011 to 2020 showed that the average population of Maghaberry and Magilligan CSUs was 2% of the respective average daily populations. It was double at Hydebank where 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

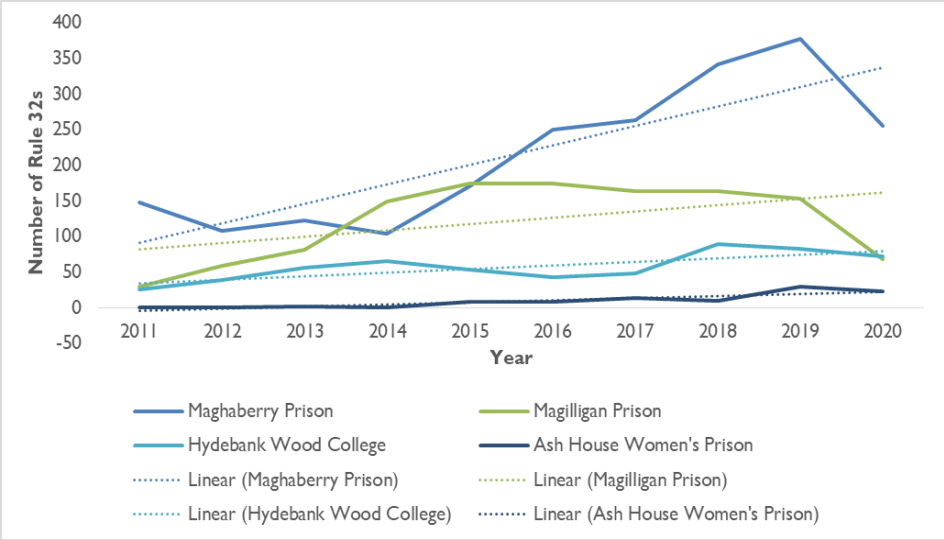
further to 11 in 2020. Recent prison inspections by CJI and its partners had identified that the level of segregation of male prisoners was higher than Inspectors normally found in England and Wales.

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 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[10] 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 because of efforts to reduce the movement of prisoners between residential units in order to manage the risk of COVID-19 infection.

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



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[11] that this approach had resulted in a degree of success in reducing the supply of drugs into prisons, however, the continued application of this

[10] 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.
[11] *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

strategy resulted in increased number of prisoners being segregated and this was not a positive outcome for 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 reduction. 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 2017 to 14 days for males and 12 days for females.

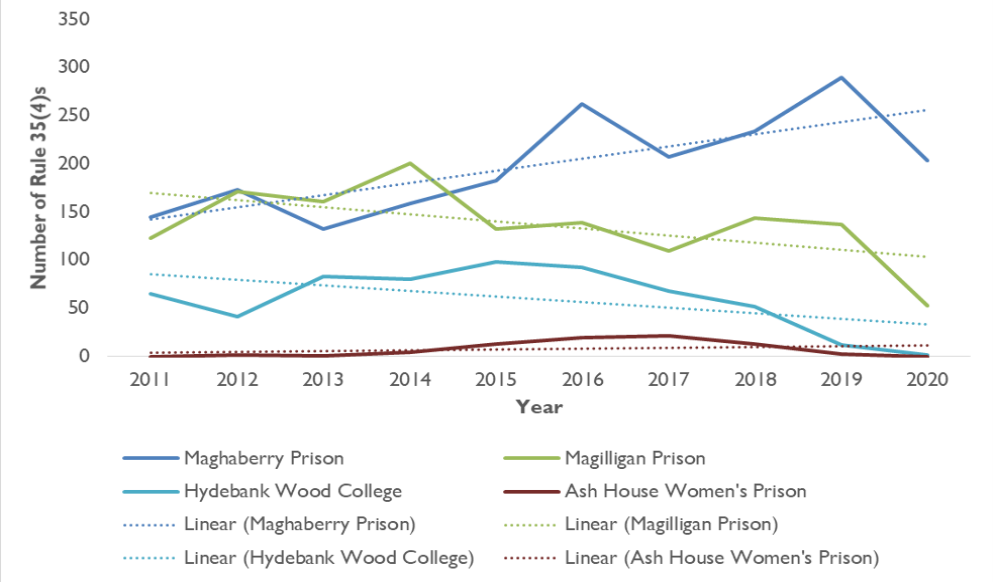
3.23 From 2015, the use of drug recovery cells had increased but had reduced in 2020 due to the pandemic. The average duration of stays in drug recovery cells ranged for two to seven days. Some individuals spent excessively long periods segregated in these cells. In 2018, one individual spent 69 days 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.

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



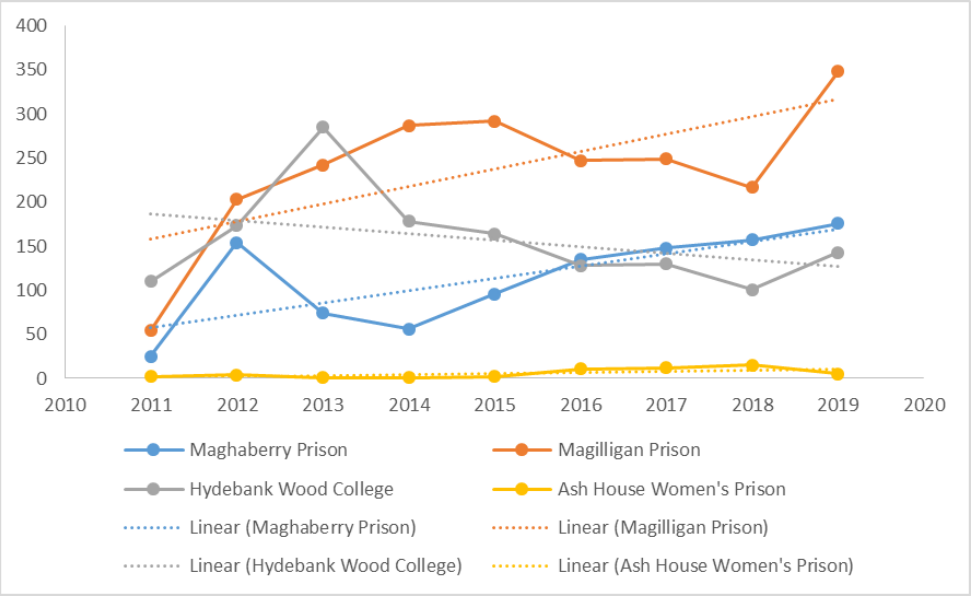
Use of cellular confinement

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).[12] This was generally consistent across each prison at just under 30% 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 4% 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 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.

[12] 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[13]

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.

3.32 Health care was informed when a prisoner arrived in a CSU. Records showed that the IMB members were not always informed within 24 hours that a

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

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 (see paragraph 3.37). 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'.[14] 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,[15] 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 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 3.71).

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 Prison 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.

[14] *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
[15] 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 IMB members. During the pandemic IMB members were not permitted to 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 IMB but had extended the period of segregation.

3.39 Requests to extend segregation periods under Rule 32 were agreed by a HQ Governor. 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 was 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.[16] 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 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 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 believe 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.

[16] *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 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% answered 'No'. In response to the same question, 46% of the general population in Maghaberry responded 'No', while at Magilligan in 2017 this was just 10%. 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 in 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% of the prisoners in the CSU at that time (nine of a possible 70 over the five-day period). 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 Prison 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 the 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 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, 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 Unit, 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 CSU to 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 The benefits of a full-time qualified and proactive librarian was strongly evident at Hydebank where an excellent 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'.[17] In the most recent surveys[18] conducted at Hydebank Wood and Ash House in 2019, 64% of the

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

woman and young men indicated that the library had a wide enough range of materials to meet their needs and almost one third (28%) indicated that they went to the library twice a week or more.

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 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[19], it was noted that the system enabled staff to accurately recorded 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

[19] *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

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.

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,[20] 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 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 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,

[20] 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.

occupational therapy, GP and dentist. This provided assurance that any health care needs already in existence prior to arrival at 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.

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 meet 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 and safety and support teams continued during the pandemic but visits by others including chaplains and 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 Mental Health team and the CSU team and managers had worked collaboratively to develop a safety plan for an individual while in 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[21] 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 oversight meetings and these measures were documented on separate proformas and by those

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

considering extension requests. 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 consistent.

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 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 the procedures SPAR[22] 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

[22] *Operating procedures for the prevention of suicide and self-harm called SPAR (Supporting Prisoners at Risk) was a collaborative approach between the NIPS, SEHSCT 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 SPAR Evolution (or SPAR EVO) now operated within NIPS.*

health crisis response service within three months of the publication of this report.

3.88 Mental health 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 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 amongst 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 CSU across the three sites. The below table provides an overview of staff allocated

Table 1: Staff allocated to CSU 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."*

3.94 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.

3.95 The current absence of a fully developed job description was unconducive 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

3.96 The experiences reported by prisoners were mixed. 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"*.

3.97 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 are more experienced. Inspectors consider the current approach to be inadequate given the nature of the role.

3.98 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.

3.99 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.

3.100 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"*.

3.101 Formal training was not provided to Governors involved in applying Rule 32, Rule 35(4) and adjudications or those responsible for extending Rule 32 periods. 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.

3.102 A NIPS 'Future Leaders' programme[23] 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

[23] 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

3.103 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.

3.104 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.

3.105 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.

3.106 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 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.

3.107 The Minister of Justice had commissioned a review of support services for operational prison staff that was completed in November 2020.[24] 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.[25] Inspectors support and herein 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.

[24] *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

[25] *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 or 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.[26] 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

[26] *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

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 The adjudication procedure '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; 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.

Case Review 1: Prisoner F, 35 years, male

The prisoner was 'awarded' five days cellular confinement. This was a 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 in segregated in CSU (the scheme had only recently been introduced at Maghaberry). Those in 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[27] 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 complementary 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."*

4.15 The experience of those suspected of concealing prohibited items also varied significantly between establishments. At Magilligan and Hydebank, prisoners lived in normal cells and a portable chemical toilet was placed in their cells, those at Maghaberry were either accommodated in dry cells,[28] which were particularly spartan, or placed in other cells without a toilet and provided with a plastic chamber pot. 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.

[27] New £54m prison block marks innovative next chapter for Maghaberry. Available at: *New £54m prison block marks innovative next chapter for Maghaberry | Department of Justice (justice-ni.gov.uk)*
[28] *A bare unfurnished cell which did not contain normal furniture, fittings, bedding or clothing.*

Provision for women

4.17 In 2011, '*The review of the Northern Ireland Prison Service*' (referred to as the PRT report),[29] 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'*. It reported the prison to be 'wholly unsuitable' and that assessment reflected considerations to specialist needs such as segregation.

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.

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'.[30] HMIP expectations for woman are underpinned by an ethos that woman, '…should no longer be held in custody which was designed for men and merely adapted slightly to accommodate women'.[31] The recent change in CSU at Hydebank from young men only to one now shared with women prisoners was a serious concern to Inspectors.

4.20 Several 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 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.

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[29] *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
[30] *Mandela Rules, United Nations Office on Drugs and Crime, The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)* available at https://www.unodc.org/documents/justice-and-prison-reform/GA-RESOLUTION/E_ebook.pdf.
[31] *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

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% of Rule 32s at Maghaberry lasted for up to three days. At Magilligan, this figure was 58% while at Hydebank it was 41%. 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% of segregation on Rule 32s was for 15 days or more at Maghaberry. At Magilligan it was 19% and at Hydebank 24%. 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.

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[32] 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 extensions there had been. 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 and Magilligan and 75% at Hydebank. Those that ended before reaching the authorised limits, generally, ended between one and three days early. It could not be determined from the data if they had ended due to decisions made by Governors at prisons or by the HQ Governor responsible for overseeing and agreeing requests to extend Rule 32. The NIPS need to better understand the reasons why Rule 32s end early 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% had been for prisoners in Maghaberry. Comparative data was not available to determine if the extensions given had agreed the periods sought by the prison,

[32] In 2019, 64% of Rule 32's ended early at Maghaberry Prison compared with 59% at Magilligan Prison and 75% at Hydebank Wood Secure College. For the same period of those which ended early 57% at Maghaberry ended between 1 and 3 days early compare with 73% at Magilligan Prison and 65% at Hydebank Wood Secure College.

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 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[33] applied to prisoners who returned from any form of temporary release. It specified that prisoners should remain in 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.

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 CSU, 14 days had already elapsed. Time spent segregated in COVID-19 isolation was in addition to periods spent in CSU. His detention was subject to the above Instruction to Governors and he stayed in 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[34] 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.

[33] *NIPS, Instruction to Governors 01/19, Passive Drug Dog (PDD) Deployment, February 2019. Not published.*
[34] BOSS chair – The Body Orifice Security Scanner is a chair with advanced body scanning technology used for the detection of concealed metal objects.

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% 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.

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 CSU accommodation[35] 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 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 the Department for the Economy 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[36] and Safety of Prisoners[37] 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% of those segregated on Rule 32 and Rule 35(4) for Maghaberry and 49% of those in Magilligan. This matter needs further analysis with regard to segregation in the CSU.

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[35] Calculated on the basis of the normal of cells available in the CSU against the average daily population for 2020.

[36] *CJI, An inspection of resettlement in the Northern Ireland Prison Service, May 2018*, available at Resettlement: An inspection of resettlement in the Northern Ireland Prison Service (cjini.org)

[37] *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 Operating procedures for the prevention of suicide and self-harm called SPAR (Supporting Prisoners at Risk) was a collaborative approach between the NIPS, the SEHSCT 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.

4.34 From 1 January 2015 to 30 November 2020, 8% 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 almost one fifth of female prisoners (18%) 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, 18% of women would be on a SPAR when they went to the new joint facility. Inspectors do not consider this a positive outcome for women.

4.35 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.

4.36 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 should be segregated in a CSU.

Those with severe mental illness

4.37 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 behavioral 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*'.[38]

[38] *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*

4.38 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.

4.39 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.

4.40 The percentage of patients segregated in a CSU in Northern Ireland prior to their transfer was over twice as high as that in England (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.

4.41 A 2017 report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) 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.[39] 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.

4.42 Data confirmed that in almost every case, patients held in Northern Ireland prisons had been transferred to hospital facilities in Northern Ireland. The current waiting arrangements in the 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.

4.43 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

[39] 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,* available at 0900001680*8ff5f2 (coe.int)*

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.

STRATEGIC RECOMMENDATION 2

The Northern Ireland Prison Service in partnership with the South Eastern Health and Social Care Trust and their governing Departments should urgently review current arrangements to ensure that prisoners suffering from severe mental disorders (including personality disorders, dementia and intellectual disabilities) are cared for and treated in a secure inpatient mental health hospital, suitably equipped and with sufficiently qualified staff to provide them with the necessary assistance. A joint feasibility paper with costed options should be submitted to the Minister of Justice within three months of publication of this report.

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

4.44 Several individuals held in CSUs were also on the Prisoner Safety and Support Team (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 CSU. Inspectors believe that prisoner outcomes will be improved by bringing these pieces of work together.

4.45 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.

4.46 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 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).[40] *Input to care planning was good and had been well documented. Contributors included; the prison psychiatrist, mental health team, governors, residential staff, PSST and AD:EPT. The prisoner had remained in CSU during fieldwork.*

4.47 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.

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

4.48 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 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.

4.49 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

[40] *Ibid footnote 23.*

privacy and the oppressive and unwelcoming environment as deterrents directly influencing the continuance of services they provided.

4.50 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.

4.51 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.

4.52 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.

4.53 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.

4.54 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.

4.55 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, 1 of 12 prisoners did not leave their cell and 3 of 12 had been out for longer than two hours.

4.56 Female prisoners were observed cleaning when out their cells, and 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.

4.57 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.

4.58 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.

4.59 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.

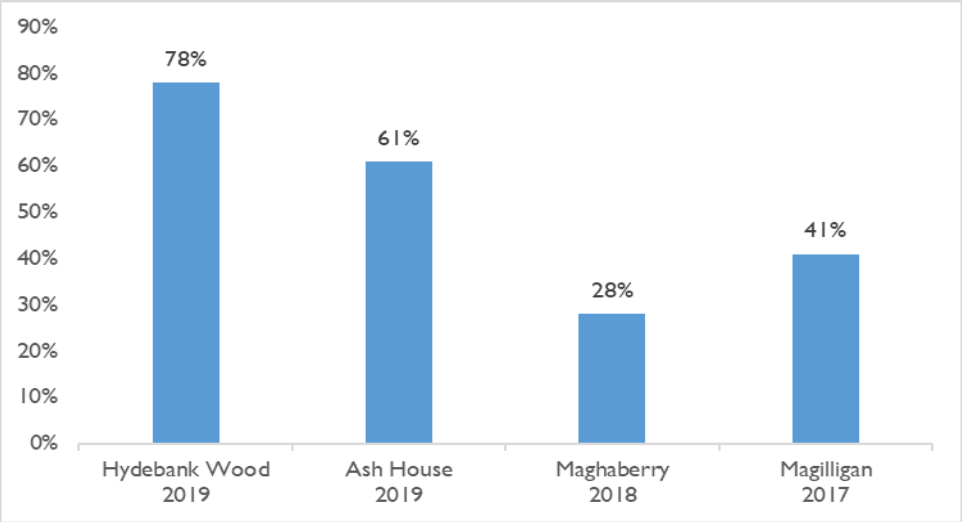
4.60 Prior to the COVID-19 pandemic service providers reported that 90% of conversations with those in CSUs took place at cell doors in the presence of CSU staff. There was a particular issue of perception of the CSU at Maghaberry where several service providers reported that the atmosphere was not welcoming.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

4.61 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.

4.62 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[41] 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.

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

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



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, 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 to 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 15 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[42], 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 previously 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 pandemic.

STRATEGIC RECOMMENDATION 3

[42] *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

The Northern Ireland Prison Service, in partnership with Belfast Metropolitan College, 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 within six months of the publication of this report, and that engagement in these activities is proactively encouraged and facilitated.

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 CSU. 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. Across the sampled six-year period, this was 61% for Catholics, which was 6% above the Catholic population for the whole prison (55%). For Protestants the figure was 28%, which was almost equal to the Protestant population for the whole prison (27%). The percentage of Catholic prisoners segregated by cellular confinement was highest at Hydebank Wood (67%) and Ash House was lowest at 49%. Table 2 provides a breakdown for all prisons.

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	27	28
Catholic	53	65	54	64	60	67	52	49	55	61
Other	19	9	14	10	18	10	21	14	18	11

4.73 A 2019 report published by Queens University, Belfast - 'Explaining Disparities in prisoner outcomes'[43] - 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.

4.74 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 s.75 monitoring and explain any disparities identified (Strategic Recommendation 2)*.[44] 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.

[43] *Queens University Belfast: Explaining Disparities in Prisoner Outcomes. Report by Butler, M., Kelly, D., & McNamee, C. 2019*, available from *Queens University.*
[44] *CJI, Equality and Diversity within the Criminal Justice System: An Inspection of the Implementation of Section 75 (1) of the Northern Ireland Act 1998, 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 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 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 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 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)[45] 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.[46]

Inspection framework

The review was conducted using HMIP's *Expectations* for men and women[47] and The Quality Standards for Health and Social Care Supporting Good Governance and

[45] *Closed Circuit Television (CCTV) - records video content but cannot record audio content*
[46] *Body Worn Camera records video and audio content when activated by staff*
[47] *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/4/2021/04/Womens-Expectations-FINAL.pdf

Best Practice in the HPSS.[48] At the time of this review, HMIP had been consulting on introducing specific Leadership Expectations.[49]

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.[50] 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.

[48] *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

[49] *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

[50] *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[51] 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".*[52]

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 Preventative Mechanism (NPM).[53] The ETI is part of the Department of Education and provides independent inspection services on the quality of education.

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).[54] 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.

[51] The Detail - *Justice and Crime*, available at https://www.thedetail.tv/investigations/solitary-confinement-69474e8b-5958-4b72-96fa-40169226f81d
[52] 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
[53] National Preventive Mechanism Website, available at https://www.nationalpreventivemechanism.org.uk/
[54] Available at https://www.ohchr.org/EN/ProfessionalInterest/Pages/OPCAT.aspx

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[55] 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 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[56] may arrange for restrictions of association (Rule 32), the keeping apart from other prisoners (Rule 35) and the use of cellular confinement (Rule 39).[57] 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.

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, wellbeing and conditions;

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

[56] 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

[57] 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

- 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.[58]

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.

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.

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

- *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 https://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 https://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[59]

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.

[59] *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.

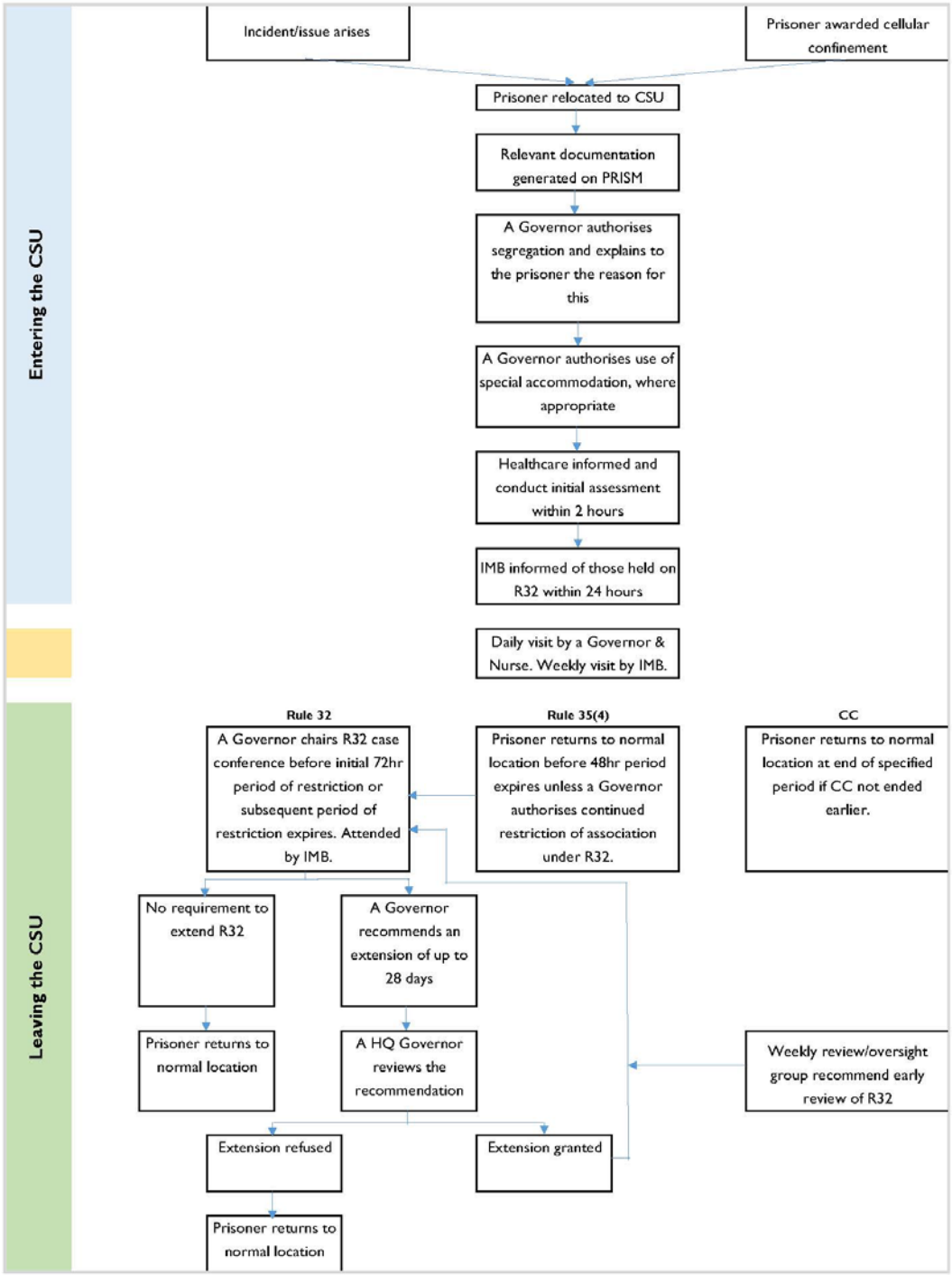
Expectation 32 - Women are encouraged and enabled to access a range of purposeful activities during their time in the segregation unit. They have access to the same range of activities, facilities and services as women on normal location.

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 April 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	x
Recovery room/cell	1	x	2	x
Dry cell	2	1 (also used for searching)	x	x
Designated dirty protest cells	x – accommodation designated as required	x- accommodation designated as required	x	x
Calm room	x	x	1	x
Adjudication room	1	1	1	
Interview room	1	1	1	
Telephone booths	2	x - Telephone on B wing	1	
Association room	x	X	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	√	√	x – table tennis table	
In-house gym	1	x - 1 piece of gym equipment on B wing	x - 1 piece of equipment in recreation room	
Sensory garden	x	1	x	
Health care room	1	1	x - on landing above	
Video conferencing facilities	x	x	x	
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 authorised 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 authorised 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.

FACTUAL ACCURACY CHECK:

A Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service (2021)

Please note: The report will subject to final proofreading and editing before publication. Please limit all responses to matters of factual accuracy only. Comments on issues such as typographical errors, punctuation and grammar are not required.

	Page/para Reference	**Statement in Draft Report**	**Agency Comment**	**CJINI Response**

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* Carried across from the NIPS document titled *'Section 1 - NIPS Themed Factual Accuracy Response.'* Comments without an asterisk are those made in and carried across from the NIPS document, *'CJINI Review into the Operation of CARE AND Supervision I=Units in the Northern Ireland Prison Service – draft'*

Ref	Page/para Reference (to copy provided on 15/10/21)	Statement in Draft Report	Agency Comment	CJINI Response
1	Para 3.4 3.40 3.52 3.57 3.58 3.65 3.84 3.96 4.60 Comments made by 1 prisoner/member of staff quoted	This comment has been applied to 9 separate paragraphs. Each has been individually reviewed and commented on separately for factual accuracy as set out below.	Subjective statements frequently stated as the view of one individual, or an unquantified few. There is a risk that undue weight is being applied to those single comments.	This comment has been applied to 9 separate paragraphs. Each has been individually reviewed and commented on separately for factual accuracy as set out below.
2	Para 3.4	Cells in Maghaberry CSU were generally bright at a satisfactory	Subjective statements frequently stated as the view of one individual, or an unquantified few.	Rejected.

	Comments made by 1 prisoner/member of staff quoted	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.	There is a risk that undue weight is being applied to those single comments.	
3	Para 3.40 Comments made by 1 prisoner/member of staff quoted	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.	Subjective statements frequently stated as the view of one individual, or an unquantified few. There is a risk that undue weight is being applied to those single comments.	Rejected.

		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.		
4	Para 3.52 Comments made by 1 prisoner/member of staff quoted	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."	Subjective statements frequently stated as the view of one individual, or an unquantified few. There is a risk that undue weight is being applied to those single comments.	Rejected.
5	Para 3.57 Comments made by 1 prisoner/member of staff quoted	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% of the prisoners in the	Subjective statements frequently stated as the view of one individual, or an unquantified few. There is a risk that undue weight is being applied to those single comments.	Rejected.

		CSU at that time (nine of a possible 70). 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".		
6	Para 3.58 Comments made by 1 prisoner/member of staff quoted	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.	Subjective statements frequently stated as the view of one individual, or an unquantified few. There is a risk that undue weight is being applied to those single comments.	Rejected.

7	Para 3.65 Comments made by 1 prisoner/member of staff quoted	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 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.	Subjective statements frequently stated as the view of one individual, or an unquantified few. There is a risk that undue weight is being applied to those single comments.	Rejected.
8	Para 3.84 Comments made by 1 prisoner/member of staff quoted	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	Subjective statements frequently stated as the view of one individual, or an unquantified few. There is a risk that undue weight is being applied to those single comments.	Rejected.

		about relationships and engagement with Primary Health Care and Mental Health Care nurses.		
9	Para 3.96 Comments made by 1 prisoner/member of staff quoted	The experiences reported by prisoners were mixed. 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".	Subjective statements frequently stated as the view of one individual, or an unquantified few. There is a risk that undue weight is being applied to those single comments.	Rejected.
10	Para 4.60 Comments made by 1 prisoner/member of staff quoted	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	Subjective statements frequently stated as the view of one individual, or an unquantified few. There is a risk that undue weight is being applied to those single comments.	Rejected.

		atmosphere was not welcoming. One told Inspectors, "In terms of the atmosphere and with the staff to that there was quite an undertone of aggression." Inspectors believe that the NIPS should take urgent remedial action on these points of learning.		
11	1.9 bullets	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 separate prisoners held at the four prisons were Rule 32(1), Rule 35(4) and Rule 39(1) (f).[1] • **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	Include: 32 (1A) should also be quoted as it is relevant to the use of rule 32 for the retrieval of any unauthorised or prohibited articles	Rejected. Paragraph 1.9 sets out the Rules providing the authority to separate prisoners and therefore Rule 32(1A) is not required.

[1] *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

		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[2], 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		

[2] *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.*

		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.		
12	Para 1.9 bullets, p13	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 separate prisoners held at the four prisons were Rule 32(1), Rule 35(4) and Rule 39(1) (f).[3] • **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	Include: Rule 95 relating to disciplinary awards for YOC	Accepted. Amendment made to improve clarity. Prison Rule 95 (1) (f) included as additional bullet point.

[3] *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

		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[4], 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		

[4] *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.*

		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.		
13	Para 3.8, p22 *"There was no designated sluice room…"*	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. 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. There was no designated sluice room for disposing of urine when special accommodation was in	NIPS has received health and safety advice that sluice rooms are required in Healthcare setting for the disposal of medical waste. The disposal of urine when special accommodation is in use in a toilet is acceptable practice.	Accepted. Operational Recommendation 3 adjusted to – *'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*

		use for drug recovery and staff were using a toilet that did not support good infection control practices. This is not acceptable and alternative arrangements need to be put in place to dispose of urine.		*effectively. Governance arrangements should be implemented to assure staff practices (paragraph 3.6).*
14	Par 3.10, p23 "*…and observation cells for those deemed at risk of self-harm…"*	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 and observation cells for those deemed at risk of self-harm and others 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.	Observation cells may be used for a number of reasons, not just for those at risk [prison rule 47/48A]	Accepted. Amendment made to improve clarity. To – '*… and observation cells for those deemed at risk of self-harm or other reasons as specified in Prison Rule 47/48A…'*
15	Par 3.17, p26 "*This included one who had been held for 366 days."*	On commencing fieldwork, 11 male prisoners were segregated in the CSUs. This included one who had been held for 366 days. There	The lack of context portrays an inaccurate picture provided. There is no recognition of the efforts staff have made to care for this individual.	Rejected.

		were no female prisoners in the CSU at Hydebank although one female prisoner was sent to the Unit for segregation during our visit.		
16	Par 3.18, p27 *"It was double at Hydebank where…"*	Data for the period 2011 to 2020 showed that the average population of Maghaberry and Magilligan CSUs was 2% of the respective average daily populations. It was double at Hydebank where 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.	This statement is inaccurate. The actual numbers, as well as percentages, should be specified. The low prisoner population at HBW would expectedly produce a higher percentage text. The paragraph does not include the context of the reason why prisoners were in the CSU (which may have been related to revised strategy to tackle substance misuse and trafficking) and therefore presents a misleading picture. Maghaberry average population 2011 – 2020 – 937 Magilligan average population 2011 – 2020 - 486 HBW average population (male) 2011 – 2020 – 128 HBW average population (female) 2011 – 2020 – 59.6 HBW average population (male & female) 2011 – 2020 – 188	Rejected. The sentence is factually accurate. Numbers added to improve clarity.
17	Par 3.20, p27 "*During 2020, the application of Rule 32 had reduced because of efforts to reduce the movement of prisoners…to manage the risk of COVID-19…"*	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	This is inaccurate. The reduction in rule 32 was directly related to the reduction in trafficking into the jail, as a result of 14 day quarantine arrangements under COVID-19 response.	Accepted. Amendment made.

		committals 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 because of efforts to reduce the movement of prisoners between residential units in order to manage the risk of COVID-19 infection.		
18	Para 3.21, p27 "*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 2017 to 14 days for males and 12 days for females."* " *…and this was not a positive outcome for prisoners."*	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 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 increased number of prisoners being segregated and this was not a positive outcome for prisoners. There is further discussion on the use of body scanners in Chapter 4.	This statement is inaccurate. This was a very positive outcome for the general prisoner population as the reduction in the supply of drugs led to a much more settled general population, with fewer incidents etc.	Accepted. Amendment made.
19	Para 3.22, p28 "*The robust approach adopted by the NIPS to*	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	The HBW figure quoted needs to also state what it increased from. The figures quoted are incorrect: Hydebank 2017 average duration of stays 2017;	Rejected. The figures quoted are not incorrect. The 2017

	reduce the supply of drugs in prisons had impacted on the average duration of stays at Hydebank and had increased from 2017 to 14 days for males and 12 days for females."	reduction. 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 2017 to 14 days for males and 12 days for females.	Male – 9 days Female – 5 days	figures have been inserted.
20	Para 3.23, p28 *"In 2018, one individual spent 69 days in a drug recovery cell at Magilligan."* *"In 2020, the maximum length of time a prisoner spent…"*	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 for 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.	As highlighted before, the context behind the individual being in a drug recovery cell is critical to understanding, rather than just giving an overall figure. NIPS has this information and is happy to share it. Again, the figures are meaningless without the context in which those individuals were in the CSU.	Rejected.
21	Para 3.27, p29 Chart 3, p30 "*Use of cellular confinement was consistently higher at Magilligan than the other*	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	This statement is inaccurate. The year 2020 was omitted from this data set – apparently due to the pandemic – yet was not omitted from the data set at Chart 2: Rule 35 (4).	Rejected. Factually accurate but figures for 2020 now included but do not alter the findings presented.

	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).”	pandemic). Data also confirmed that cellular confinement was used sparingly for women at Ash House. At Hydebank 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.	When 2020 is included, it shows a very different picture, with a significant downward trend for males at HBW. The paragraph and the Chart should be redrafted/replaced  10 Year Dataset - Combined - Amende	
22	Para 3.31, p30 *“Records need to contain greater detail along with evidence that prisoners fully understand the rationale for decisions to segregate in the CSU.”*	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.	Advice on how NIPS can “evidence” that a prisoner understands would be appreciated.	Rejected.

23	Para 3.37, p32 *"During the pandemic IMB members were not permitted to attend Rule 32 reviews for a period and arrangements were made to review documentation away from the CSU."*	Overall IMB members reported that Governors and staff were responsive to issues raised by them. During the pandemic IMB members were not permitted to 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.	This is not accurate. <u>At the time it was the choice of IMB members not to attend mostly because most of their members were isolating due to Government Guidance</u>.	Partly accepted. Amendment made to improve clarity. To - *'During the pandemic IMB members did not attend Rule 32 reviews for a period and arrangements were made to review documentation away from CSUs...'*
24	Para 3.39, p32 *"Requests to extend segregation periods under Rule 32 were agreed by a HQ Governor"*	Requests to extend segregation periods under Rule 32 were agreed by a HQ Governor. 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	This statement is inaccurate. The extensions are considered and agreed by a Governor from HQ who is not acting as a Governor, but as the independent Authorising Officer on behalf of the Department of Justice.	Rejected. Role is explained at para 2.6.

		routinely explained on the documentation reviewed by Inspectors.		
25	Para 3.41, p32 Whole paragraph	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.	Existing arrangements for Rule 32 case conferences are that Healthcare in Prisons team, PSST, Security, IMB, Govs are invited to attend each case conference. Perhaps a recommendation here is appropriate for SEHSCT.	Rejected. CJI would expect that the question of how Governors access all relevant information should be considered as part of the review of Rule 32 under Strategic Recommendation 1.
26	Para 3.43, p33 *"At Magilligan and Hydebank they were chaired by the Deputy Governor and at Maghaberry chaired by the Functional Head of Residential and Safer Custody".*	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.	These posts are all at the same rank – it reads as though lesser importance is applied at MGBY, which is not the case and therefore inaccurate.	Rejected.
27	Para 3.44, p33	Unlike Rule 32 case conferences, oversight meetings had greater	NIPS forensic psychology, or SEHSCT clinical psychologists? The statement is inaccurate as	Rejected.

	"There were gaps in contributions, for example, from learning and skills and psychology staff."	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.	it implies that these staff were on site and accessible – at the time of the fieldwork, these staff were not on site in the prisons.	Amendment made to improve clarity to show that the reference referred to NIPS psychology staff. It is not implied that the staff were on site.
28	Para 3.44, p33 *"Both had significant contributions to make…*	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	Perhaps replace "had" and insert "may have had"	Rejected.

		gaps in contributions, for example, from learning and skills and psychology staff. Both had significant contributions to make and should contribute to this process.		
29	Par 3.50, p34 "*Maghaberry had commenced a new monthly Rule 32 audit but largely focussed on procedural practice rather than on improved outcomes for prisoners."*	Maghaberry had commenced a new monthly Rule 32 audit but it largely focussed on procedural practice rather than on improved outcomes for prisoners.	That is exactly what it was meant to do – it encouraging that inspectors have confirmed it was working effectively, but disappointing that it has been turned it into a negative.	Rejected.
30	Par 3.55, p35 "*In response to the same question, 46% of the general population in Maghaberry responded 'No', <u>while at Magilligan in 2017 this was just 10%."</u>*	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% answered 'No'. In response to the same question, 46% of the general population in Maghaberry responded 'No', while at Magilligan in 2017 this was just 10%. When Inspectors reviewed a selection of request sheets, there were no requests recorded for showers at weekends. Inspectors also noted	If the issue being raised is Maghaberry what relevance does Magilligan responses have? Is there data available as to how the Maghaberry survey responses equate to comparative prisons?	Rejected. In this section we compared the findings for the two adult prisons in Northern Ireland. Figures added and % added.

		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.		
31	Par 3.67p38 "*Two pieces of gym equipment were also available in the CSU recreation room but inspectors did not observe them being used."*	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.	By prisoner choice? Prisoners cannot be compelled to use equipment	Rejected.
32	Par 3.68, p38 *"The benefits of a full-time and qualified librarian was strongly evident"*	The benefits of a full-time qualified and proactive librarian was strongly evident at Hydebank where an excellent service was provided to both prisons. The librarian had scheduled visits and was observed visiting the CSU during the	Maghaberry also has two librarians – the wording of this sentence has the potential to criticise the work that they do as it is officers fulfilling this role.	Accepted. Amendment made to improve clarity. To - *'In Hydebank an excellent library service*

		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'. In the most recent surveys conducted at Hydebank Wood and Ash House in 2019, 64% of the women and young men indicated that the library had a wide enough range of materials to meet their needs and almost one third (28%) indicated that they went to the library twice a week or more.		*was provided to both prisons.'*
33	Par 3.71, p39 Entire paragraph	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.	The wording of the paragraph presents an inaccurate picture. In completing daily request sheets/journals, CSU staff are fulfilling the need to have operational records to enable us to complete everyday tasks. The purpose is not to provide "longitudinal information".	Rejected.

34	Para 3.73, p40 *"several prisoners said if they had wanted to speak to the Governor about something personal it would have been awkward, as everyone could have heard them, including other prisoners*"	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, 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 it would have been awkward, as everyone could have heard them, including other prisoners.	This is personal opinion and appears to be hypothetical – there is no specific instance(s) quoted where this had actually happened.	Rejected. Text added to improve clarity.
35	Para 3.74, p40 *"Records Inspectors examined did not demonstrate that Duty Governors routinely checked landing journals or requests sheets to inform their visits with prisoners*	Records Inspectors examined did not demonstrate that Duty Governors routinely checked landing journals or requests sheets 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	This statement is inaccurate. Request & Complaint system is fully automated and does not necessitate the checking of request or complaint sheets by Duty Governors unless that request or complaint has been forwarded to the individual or department. If a formal written request is submitted, it will be recorded on PRISM and directed to the most appropriate person – other non-formal	Rejected. Amendment made to improve clarity. New footnote added to indicate that the request sheets referred to are the daily requests sheets

	and that they relied on officers to confirm what requests had been made by prisoners"	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.	or verbal requests are managed at a lower level and could be reported via word of mouth if appropriate.	completed at Maghaberry and as referenced earlier at paragraph 3.54.
36	Para 3.76, p41 *"IMB weekly visits to CSUs had resumed at Maghaberry but not at Magilligan and HBW"*	Visitor logs showed that support from staff in AD:EPT, the mental health team and safety and support teams 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.	Each establishment had agreed through the Executive Forum that IMB could come on site and all the paperwork would be brought to them – in MGN they used their own office, the paperwork was photocopied, placed in clear sleeves and they used PPE gloves during their reviews. This was consistent with MGN and HBW. The context of the pandemic here is important as most of the IMB members were self-isolating due to Government advice. In the absence of the context, the comment is misleading and inaccurate.	Rejected. Not inaccurate. As stated in the report, the lack of IMB presence was for various reasons.
37	Para 3.77, p41	The Rule 32 documentation reviewed by Inspectors that	This statement is inaccurate. As commented on earlier, this sits with the healthcare	Rejected.

	"…risk assessment or problem formulation."	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 Mental Health Team (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.	assessment on entry to the CSU and followed up by daily visits. Any concern whatsoever about the individual can be picked up by the medical professional, or through member of staff notifying a healthcare professional. Where there is a concern that someone may be at risk of suicide or self-harm, the SPAR Evolution approach applies as it does for any other prisoner, irrespective of their location in the prison	See later comment re work at Magilligan in the same paragraph.
38	Para 3.81, p42 "*The NIPS estate has no health care in-patient facility".*	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	This is entirely in keeping with the Expectations standards for Health, Wellbeing and Social care (Patients receive secondary care services within community).The SEHSCT direction is that prisoners who need hospital treatment will be assessed/treated in	Rejected.

		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.	a hospital. NIPS facilitates this to happen. The text should reflect this.	
39	Para 3.78, p42 *"Exit planning was also considered at oversight meetings and these measures were documented on separate proformas and by those considering extension requests."*	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 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 oversight meetings and these measures were documented on separate proformas and by those considering extension requests. 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	Rule 32 oversight meetings are not for the purpose of considering an extension. Rule 32 oversight meetings examine the current status, provision and if an early review for exit from Rule 32 is appropriate.	Rejected. Not a point of factual accuracy. Text added to improve clarity, i.e. Inspectors are referring to the role of HQ Governors as explained previously at Par 2.6

		detention. There was limited evidence in the paperwork provided that reintegration plans were routinely developed for those leaving CSUs.		
40	Para 3.80, p42 "*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."* Par 3.82, p42 *"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*	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.	Is this not contradictory to the previous statement regarding Governors' fitting people for adjudication and also the reference to SET not fitting people for adjudication (3.83). This also demonstrates that the process under IG 04/18 is effective.	Rejected. This deals with how people exit CSU when on CC and follows earlier paragraphs setting out how those on Rule 32 exit. This paragraph and 3.82 refer to the situation when people are already held in CSU. Chapter 2 of the report deals with IG 04/18. There is no contradiction here.

	about the health of all prisoners held in CSUs."			
41	Para 3.84, p43 "However, *some prisoners told inspectors about long waiting times to see a GP, although this was comparable to waiting times in the community"*		Opinion, not fact – it should be noted that waiting times in prison are comparable to the community?	Rejected. Report content acknowledges comparable waiting times in the community.
42	Para 3.86, p43 footnote 22 "…*called SPAR (Supporting Prisoners at Risk)…"*	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 the procedures SPAR or, to consider transfer of a prisoner to the local Emergency Department to maintain safety and minimise risk.	This statement is inaccurate. SPAR (Supporting People at Risk) Evolution.	Accepted. SPAR and SPAR Evolution are now fully explained at the definition section. Added – *'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 NIPS, SEHSCT 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.'
43	Para 3.94, p45 *"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."*	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.	This is out of context and therefore inaccurate, the job role information provided was for the purpose of outlining operational responsibilities, not for the recruitment of staff to the CSU.	Accepted. Amendment made to improve clarity.
44	Para 3.96, p45 Examples.	The experiences reported by prisoners were mixed. 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	The reporting is unbalanced with one positive quote about staff and 3 negative (which is an inaccurate portrayal). All four quotes are opinion based- not fact. The reviews carried out on SPAR Evo reflected very positive quotes about staff.	Rejected. The report is evidenced based, balanced and fair and is not an inaccurate portrayal.

		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".		This was a review of CSU not a review of SPAR Evo. Text added to improve clarity: *'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.'*
45	Para 3.101, p46 *"Formal training was not provided to Governors in applying rule 32, 35(4) and adjudications or those responsible for extending Rule 32".*	Formal training was not provided to Governors involved in applying Rule 32, Rule 35(4) and adjudications or those responsible for extending Rule 32 periods. 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.	This is inaccurate. In September 2015, following promotion boards to Unit Manager, formal training in adjudications was delivered to 13 newly promoted Governors and 1 existing Governor. Formal training was required for every governor and was delivered by a suitably qualified practitioner and a list was maintained of those who completed the training and found suitable, as far back as the last 15yrs "Judge Over My Shoulder" training has been delivered to Governors by DSO, and by the NIPS Legal Adviser who holds a formal training qualification. A number of 1-2 hr training sessions were delivered to	Rejected. Provision of training is not disputed. Amendment made to improve clarity.

			Governors between the end of 2018 and beginning of 2019 at each establishment and NIPS HQ by our Legal Adviser. The sessions covered the requirements under the Rules and discussing cases that had gone to court in great detail. A further part of the sessions was delivered by Counsel specifically in relation to giving a gist to the prisoner at the invocation of Rule 32. Furthermore, as a result of the sessions and the Aiken case, all establishments introduced the weekly informal review of those on Rule 32, which is over and above the requirements under the Rules. It is also interesting to note that the number of legal challenges around the invocation of Rule 32 has significantly reduced. During the review of CCTV footage at NIPS HQ, the NIPS legal Adviser offered to speak to the Inspector, but that offer was not taken up.	
46	Para 3.107, p47	The Minister of Justice had commissioned a review of support services for operational prison staff that was completed in November 2020. 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	A pilot re recommendation 7 of the support services review report starts in HBW on the 01 November 2021	Noted.

		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. 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.		
47	Para 4.7, p49 "…*prisoners at all sites still referred to the CSU as, "the block..."*	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. 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	People in custody have nicknames for most things. For example, people in custody frequently refer to officers as "screws" and prisons as "jails". The connotation is misleading and therefore inaccurate	Rejected. Not misleading nor inaccurate.

		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.		
48	Para 4.8, p49 *"The adjudication procedure "awarded" punishments that resulted in prisoners being sent to the CSU with an outcome resulting in segregation in cellular confinement."*	The adjudication procedure '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; some of which was determined by the NIPS and on occasions, use that was manipulated by the prisoners themselves.	The drafting is misleading/inaccurate as it does not include the other awards that can be made (and more importantly are made) under Rule 39. It does not include the volume of other awards v awards for cc. It implies that cc is the only award that is made following the adjudication process, which is inaccurate. It furthermore does not add any context as to the story behind why an individual has been awarded cc in the first place.	Rejected. None of the other awards resulted in prisoners being sent to CSU. Rule 39 and range of awards is set out in full in Chapter 1 para 1.9. Amendment made to improve clarity.
49	Para 4.8, p49 *"It is the view of the 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 the use of*	The adjudication procedure '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,	Could the author explain what they mean by "*not limited to just punishment but extended far beyond this"?*	Accepted. Amendment made to improve clarity.

	the CSU was not limited to just punishment but extended far beyond this;"	and as outlined in this report, that use of the CSU was not limited to just punishment but extended far beyond this; some of which was determined by the NIPS and on occasions, use that was manipulated by the prisoners themselves.		
50	Para 4.9, p49 Whole paragraph	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.	This para is contradicted by others throughout the report including 3.81 – 3.91, 3.62, 3.65-3.68 and others.	This comment has been applied to 17 separate paragraphs. Each has been individually reviewed and commented on separately for factual accuracy as set out below.
51	Para 4.9, p49 Whole paragraph	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	This para is contradicted by others throughout the report **including 3.81**	Rejected.

		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.		
52	Para 4.9, p49 Whole paragraph	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.	This para is contradicted by others throughout the report **including 3.82**	Rejected.
53	Para 4.9, p49 Whole paragraph	Current use of the CSU had resulted in providing accommodation for prisoners with a complex range of needs. Many prisoners found themselves in the	This para is contradicted by others throughout the report **including 3.83**	Rejected.

		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.		
54	Para 4.9, p49 Whole paragraph	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.	This para is contradicted by others throughout the report **including 3.84**	Rejected.
55	Para 4.9, p49 Whole paragraph	Current use of the CSU had resulted in providing accommodation for prisoners with	This para is contradicted by others throughout the report **including 3.85**	Rejected.

		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.		
56	Para 4.9, p49 Whole paragraph	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.	This para is contradicted by others throughout the report **including 3.86**	Rejected.

	Para 4.9, p49 Whole paragraph	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.	This para is contradicted by others throughout the report **including 3.87**	Rejected.
57	Para 4.9, p49 Whole paragraph	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	This para is contradicted by others throughout the report **including 3.88**	Rejected.

		restricted regimes regardless of why they were held there.		
58	Para 4.9, p49 Whole paragraph	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.	This para is contradicted by others throughout the report **including 3.89**	Rejected.
59	Para 4.9, p49 Whole paragraph	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	This para is contradicted by others throughout the report **including 3.90**	Rejected.

		case and all prisoners in the CSU were subject to similar and restricted regimes regardless of why they were held there.		
60	Para 4.9, p49 Whole paragraph	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.	This para is contradicted by others throughout the report **including 3.91**	Rejected.
61	Para 4.9, p49 Whole paragraph	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	This para is contradicted by others throughout the report **including 3.62**	Rejected.

		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.		
62	Para 4.9, p49 Whole paragraph	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.	This para is contradicted by others throughout the report **including 3.65**	Rejected.
63	Para 4.9, p49 Whole paragraph	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	This para is contradicted by others throughout the report **including 3.66**	Rejected.

		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.		
64	Para 4.9, p49 Whole paragraph	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.	This para is contradicted by others throughout the report **including 3.67**	Rejected.
65	Para 4.9, p49 Whole paragraph	Current use of the CSU had resulted in providing accommodation for prisoners with a complex range of needs. Many prisoners found themselves in the	This para is contradicted by others throughout the report **including 3.68**	Rejected.

		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.		
66	Para 4.9, p49 Whole paragraph	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.	This para is contradicted by others throughout the report including 3.81 – 3.91, 3.62, 3.65-3.68 **and others.**	Rejected.
67	Para 4.10, p49 Whole paragraph	The NIPS viewed loss of liberty to be the punishment and that cellular confinement must only to be	Prison Rule 39(4) provides for where a prisoner is found guilty of more than one charge arising out of an incident. The context	Rejected.

		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.	of the reasons why the individual has been awarded cc is missing, as is the extent to which this is an issue, which presents an inaccurate picture. The NIPS adjudication manual states at para 6.11, "generally adjudicators should only award cellular confinement in respect of serious or repeated offences."	Guidance by the Attorney General for Northern Ireland on the international human rights standards of most relevance and assistance to the NIPS was provided in 2014. This either supplemented the Prison Rules or constituted a guide to how the Prison Rules should be applied. Rule 36 (Mandela) states in relation to Restrictions, discipline and sanctions, that no more restriction than is necessary should be used to ensure safe custody, the secure operation of the prison and a well ordered community life. The European prison Rules state that *'prisoners who are separated shall not be subject to further restrictions beyond those necessary for meeting the stated purpose of such separation'*. HMIP Expectations are clear

				that, *'No unofficial or collective punishments are used'*. Awards of CC are not challenged and no further context is required. A statement that, *'generally adjudicators should…'* is not relevant to the context. At MGN Gov. Order H9 stated, ***'Normally**, prisoners undergoing a period of cellular confinement will lose those privileges identified at adjudication' CC* was awarded in conjunction with other punishments. The reasons why prisoners were awarded CC is not in dispute but the context of why the individual was awarded CC was not always recorded on the documentation reviewed.

				We have stated, it was, *'not normal practice'* and this remains factually accurate.
68	Para 4.11, p49 *"…where a prisoner already in the CSU on Rule 32 was punished through demotion in regime under PREPS."*	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.	The context as to the circumstances leading to the demotion under PREPs needs to be understood. If inspectors expect the same level of access and treatment across general population & CSU, then it must also expect that rules re the conduct of those held within the CSU and the general population also need to be applied in the same way.	Rejected. This comment challenges HMIP Expectation 11, i.e. that *'segregated prisoners have daily access to the telephone and a shower and are encouraged to access an equitable range of purposeful activities.'* A key indicator is that, *'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.'* The Expectations make a clear distinction between the treatment of individuals held in a segregation and those

				on normal landings. The comment appears to ignore the impact of a demotion in regime on those who already experiencing a restricted regime in the CSU. Those in CSU could not access the same enhanced privileges when located in the CSU. It is also worthy of note that those on Rule 32 had not been charged with any offence under prison rules.
69	Para 4.15, p50 "*those at Maghaberry were either accommodated in dry cells, which were particularly Spartan, or placed in other cells without a toilet and provided with a chamber pot"*	The experience of those suspected of concealing prohibited items also varied significantly between establishments. At Magilligan and Hydebank, prisoners lived in normal cells and a portable chemical toilet was placed in their cells, those at Maghaberry were either accommodated in dry cells, which were particularly spartan, or placed in other cells without a toilet and provided with a plastic chamber pot. At Magilligan and Hydebank, new cell furniture was either being	Dry cells are those cells without a toilet in which chamber pots were used – the wording of this is inaccurate and suggests we have both dry cells and cells which do not have toilets, which is incorrect.	Accepted. Amendment made to improve clarity. To – *'The experience of those suspected of concealing authorised or prohibited items also varied significantly between establishments. 'Recovery Cells' were used to aid the*

		tested or due to be tested but there were no plans to do the same at Maghaberry.		*retrieval of any authorised 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 authorised 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.'*

70	Para 4.16, p79 "*no evaluation/review had been conducted of either Davis House……"*	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.	In keeping with the rest of the world, we have been responding to a pandemic where only essential staff are permitted into the prison to minimise the risk of transmission of COVID-19 to the prison population and this is rightly where our focus has had to be. Review will be completed if appropriate and at a time when NIPS has the capacity to do so. This statement inaccurately portrays the position by omitting the context of the pandemic.	Rejected. This comment is unnecessary.
71	Para 4.17, p53*	In 2011, *'The review of the Northern Ireland Prison Service'* (referred to as the PRT report), 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'. It reported the prison to be 'wholly unsuitable' and that assessment reflected considerations to specialist needs such as segregation.	The PRT report [2011] is 10 years old. The reference to the PRT Report 2011 does not add to the commentary as it conflicts with the most recent joint CJINI/HMI Inspection of Ash House [2019], which comes to a contrary conclusion. The PRT report does not make any specific reference to segregation in Ash House and is therefore irrelevant to this report. The last line of para 4.17 of the report is inaccurate and misleading.	Rejected. Amended to provide further clarity on points identified by CJI. This paragraph provides background to the female prison. From - It reported the prison to be *'wholly unsuitable'* and that assessment reflected considerations to specialist needs such as segregation.

				Text changed to - 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'.*
72	Par 4.20, p51 "*Several mentally unwell women had been held in the CSU ending transfer on TDO since its opening."*	Several 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 had on the whole environment and the efforts of staff to maintain privacy and dignity for the individual concerned.	How many, for what duration and what was the context behind their removal to the CSU? It is unlikely that efforts to maintain privacy and dignity for the individual quoted would have been any less in Ash House.	Rejected. The data will be updated to the time of publishing to reflect the exact figures.
73	Para 4.22, p52 Figures	From 1 January 2019 to 30 November 2020, 41% of Rule 32s at Maghaberry lasted for up to three days. At Magilligan, this figure was	The figures are not helpful without the context of why the individuals had been segregated under Rule 32 – particularly the one woman segregated for over 42 days.	Rejected. This report acknowledges the

	"Some individuals were segregated for significant proportions of their overall time in custody"	58% while at Hydebank it was 41%. 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% of segregation on Rule 32s was for 15 days or more at Maghaberry. At Magilligan it was 19% and at Hydebank 24%. 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.	An accurate account cannot be established with this information missing.	difficult circumstances and challenges presented by those held in CSUs. This was a review of treatment and conditions in CSUs and not an investigation of individual prisoners.
74	Para 4.22, p52 Figures *"Some individuals were segregated for significant proportions of their overall time in custody"*	From 1 January 2019 to 30 November 2020, 41% of Rule 32s at Maghaberry lasted for up to three days. At Magilligan, this figure was 58% while at Hydebank it was 41%. 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% of segregation on Rule 32s was for 15 days or more at Maghaberry. At Magilligan it was 19% and at	How many is "some"? What constitutes "significant" proportions of overall time in custody? An accurate account cannot be established with this information missing.	Accepted. Figures now included in the report.

		Hydebank 24%. 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.		
75	Para 4.23, p52 "*However, the data did not show how many previous extensions there had been."* *"Inspectors noted that it was not routinely captured and used…"*	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[5] 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 extensions there had been. 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.	This data is available on PRISM and available on hard copy if requested. The statement is inaccurate as had it been requested, it would have shown extensions etc.	Rejected. This information was requested. Text changed to – *'However, the data did not show how many previous extensions requests there had been to HQ.'*

[5] In 2019, 64% of Rule 32s ended early at Maghaberry Prison compared with 59% at Magilligan Prison and 75% at Hydebank Wood Secure College. For the same period of those which ended early 57% at Maghaberry ended between 1 and 3 days early compare with 73% at Magilligan Prison and 65% at Hydebank Wood Secure College.

76	Para 4.23, p52 "*However, the data did not show how many previous extensions there had been."* *"Inspectors noted that it was not routinely captured and used…"*	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[6] 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 extensions there had been. 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.	All data on Rule 32s with regard to the start and end dates and the number of extensions are captured as confirmed in 4.25.	Rejected. Text added to improve clarity. This paragraph deals with the proportion of requests agreed by HQ and what oversight there was of those decisions.
77	Para 4.23, p52 "*However, the data did not show how many previous extensions there had been."*	Segregation on Rule 32 was permitted for up to an initial 72 hours or up to 28 days for extended periods agreed by NIPS	I would suggest of more importance than the number of extensions is the overall time a person spends on Rule 32. In theory all Rule 32s could be extended for up to 28 days at each extension; the fact that they are not, shows that NIPS operates according to the	Rejected.

[6] In 2019, 64% of Rule 32s ended early at Maghaberry Prison compared with 59% at Magilligan Prison and 75% at Hydebank Wood Secure College. For the same period of those which ended early 57% at Maghaberry ended between 1 and 3 days early compare with 73% at Magilligan Prison and 65% at Hydebank Wood Secure College.

	"Inspectors noted that it was not routinely captured and used…"	HQ. Data[7] 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 extensions there had been. 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.	specific circumstances of each Rule 32 and the changes that can take place during the period on Rule 32 and; therefore, no one spends any longer on Rule 32 than is necessary.	
78	Para 4.24, p52 "*Those that ended before reaching the authorised limits, generally, ended between one and three days early. It could not be determined from the data if they had ended due to decisions made by*	The figures were lower in 2020. Just over 50% of Rule 32s ended before reaching the maximum authorised limits at Maghaberry and Magilligan and 75% at Hydebank. Those that ended before reaching the authorised limits, generally, ended between one and three days early. It could not be determined from the data if they had ended due	This is incorrect, it would be a local decision to end the Rule 32 early due to an oversight meeting. The Governor attending is for the purpose of authorising or not authorising the extension period when the current period is about to expire, and on behalf of the Department. This is an inaccurate statement. Each case is an individual and those that end early are due to the risks that led to an individual being on	Accepted. Amendment made. From – *'It could not be determined from the data if they had ended due to decisions made by Governors at prisons or by the HQ Governor*

[7] In 2019, 64% of Rule 32s ended early at Maghaberry Prison compared with 59% at Magilligan Prison and 75% at Hydebank Wood Secure College. For the same period of those which ended early 57% at Maghaberry ended between 1 and 3 days early compare with 73% at Magilligan Prison and 65% at Hydebank Wood Secure College.

	Governors at prisons or by the HQ Governor responsible for overseeing and agreeing requests to extend Rule 32" *"NIPS need to better understand the reasons why Rule 32's end early and use this learning to influence better outcomes for other segregated prisoners."*	to decisions made by Governors at prisons or by the HQ Governor responsible for overseeing and agreeing requests to extend Rule 32. The NIPS need to better understand the reasons why Rule 32s end early and to use this learning to influence better outcomes for other segregated prisoners.	Rule 32 reducing in their particular circumstances.	*responsible for overseeing and agreeing requests to extend Rule 32.'* To – *'Data on the reasons why Rule 32s ended early or the full extension periods requested had not been granted was not centrally recorded.'*
79	Para 4.30, p54 *"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 CSU accommodation[35] 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*	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 CSU accommodation 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.	This is inaccurate. Cellular capacity was increased for males when the CSU was relocated from the old CSU to Elm 1 CSU and was attributable to the cells available on the existing landing – not because of a desire to increase the number of people who could held (which the drafting implies) Four cells were made available on Fern 1 CSU as an annex of the existing Fern 1 landing, which had previously been redesigned to accommodate a republican prisoner and was more recently used by kitchen workers. Available space was reduced from the six cells that were previously available on Ash 1 to four on Fern 1 CSU. The capacity per 100 prisoners are always going to be much higher at HBW due to the	Rejected.

	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."		small young offender and female populations. The paragraph should reflect this, as it is misleading as it stands. It also does not reflect the different needs/responses related to female and young offender populations	
80	Para 4.31, p54 *"The NIPS advised it was waiting on final authority from the Department for the Economy to introduce scanners and they had well progressed plans in place for staff training and implementation."*	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 the Department for the Economy to introduce scanners and they had well progressed plans in place for staff training and implementation.	Please replace the Department for the Economy with a Justifying Authority	Accepted. Amended to *'a Justifying Authority'*

		As was currently the case in England and Wales, scanners were not being used for women in Northern Ireland prisons.		
81	Para 4.33, p55 Whole paragraph	Operating procedures for the prevention of suicide and self-harm called SPAR (Supporting Prisoners at Risk) was a collaborative approach between the NIPS, the SEHSCT 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.	This is inaccurate. Under SPAR Evolution "SPAR" stands for "Supporting People at Risk" and it is a multidisciplinary approach which is person-centred and aims to support people through a period of crisis or distress, while also addressing the root-cause of the crisis or distress where possible.	Accepted. Amended to provide further clarity on SPAR Evo. For continuity, SPAR and SPAR Evo is now dealt with under Definitions from the outset of the report. Paragraph deleted.
82	Para 4.34, p55 "*From 01 January 2015 – November 2020 8% 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 time almost one fifth of female prisoners (18 %)…"*	From 1 January 2015 to 30 November 2020, 8% 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 almost one fifth of female prisoners (18%) 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,	These figures are not accurate. Checks by NIPS staff have shown that individuals who were on a SPAR at the time they were charged or adjudicated on, were not on a SPAR or (Care Plan under SPAR Evo) when they entered the CSU. From 2015 – 2020 7% of males were on a SPAR when placed on Rule 32 which is 369 instances and 187 individuals across the three establishments. Also there is no context provided, below is an example of when this has occurred; *Prisoner A is committed to custody on 14/02/20, they present as under the influence and during the committal interview and advise staff that they*	Accepted in part. The figures supplied are not supported by corroborating evidence (such as new data sets). Our analysis is based on the data sets provided by NIPS early in the inspection which we have reviewed. Based on this evidence and the information now provided, we have removed Rule35(4)s from our original

	"If that trend continued, 18% of women would be on a SPAR when they went to the new joint facility"	18% of women would be on a SPAR when they went to the new joint facility. Inspectors do not consider this a positive outcome for women.	*have a history of self-harm. The individual disclosed that they had taken a substantial amount of drugs prior to entering custody and could not confirm if they were able to keep themselves safe, A SPAR Evo was opened. Due to the individual presenting as heavily under the influence there were concerns that they may have items concealed on their person and are placed on Rule 32. As nothing had been recovered from the individual and they were no longer presenting as under the influence they were relocated from the CSU to general population. On that same day a package was recovered from the individual's cell and they were returned to the CSU and placed on Rule 35(4). The individual was then placed on Rule 32 due to ongoing concerns that they had items concealed on their person. During this period of Rule 32 there were two periods of 7 day extensions requested and authorised. The SPAR remained active during this time to provide the individual with the appropriate support and was closed 5 days after the conclusion of the Rule 32.* The total for females is incorrect, this is 14%. Again there is no context provided in terms of the population size which results in a higher percentage. From 2015 – 2020 the total number of females that were on a SPAR when placed on Rule 32 is 14. Overall the data demonstrates that the number of individuals placed on Rule 32 when subject to	calculations and amended some data accordingly.

			SPAR/SPAR Evo monitoring is on a downward trend during this same time period. Please also note that this data highlights if a SPAR is active on Rule 32 date. This means that in some instances the SPAR may have been opened after the commencement of Rule 32. That is pure supposition and has no basis bearing in mind a) the figures quoted are not sound and there has been no analysis made of the period October 2020 – Feb 2021 when the field work was being completed.	
83	Para 4.35, p55 Whole paragraph	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.	This is inaccurate. The old SPAR Process and SPAR Evolution are multidisciplinary, with input from healthcare. Under SPAR Evo, where an individual is known to the Mental Health Team, they provide the input to care planning. As above, NIPS checks have shown that individuals who were on a SPAR/Care Plan when charged, were not necessarily on a SPAR/Care Plan when adjudicated on or when they entered the CSU. To say *"The outcome for these meant that they had already entered the CSU without assessment by healthcare professionals"* is incorrect.	Rejected. Text changed to improve clarity. To – *'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.'*
84	Par 4.36, p55	From 2015, the average duration of time spent in observation cells in CSUs was mostly consistent across	This is inaccurate. The context behind the cases quoted should be cited (observation cells are not just for people who are on a	Rejected.

	"*Inspectors did not agree that prisoners who were on a SPAR should be segregated in a CSU."*	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 should be segregated in a CSU.	SPAR/SPAR Evo care plan). An observation cell is an observation cell irrespective of its location. This statement does not take into account the number of possible scenarios in which a person may be in a CSU e.g. a person, despite being on a SPAR, may have assaulted another person or have drugs concealed or displayed behaviours that could not be managed in a residential location. It also conflicts with HMIP Expectations which state "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." The inference being that they can be segregated.	Change made to improve clarity to – *'Inspectors did not agree that prisoners who were on a SPAR 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).'*
85	Par 4.37,p55 Description of medical markers	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 behavioral 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	The text is misleading and inaccurate– not every prisoner who is held in the CSU has medical markers and, for example, 53% of prisoners have the medical marker applied "self-harm/history of self-harm" but the number of people who actively self-harm is lower. Medical markers are set a committal by healthcare, but are not always updated. There is no mental illness/mental issue marker, so nurses use the severe mental illness marker for any sort of mental health issue.	Rejected. The statement is factually accurate. The commentary on paragraph 4.37 states that PRISM records are inaccurate because they are *"not always updated"* but provides no assurance of effective remedy. In effect, this raises wider concerns about the integrity of

		that, 'Work is also needed by the wider criminal justice and health care systems to provide alternatives to custody for highly vulnerable prisoners'.		PRISM and about matters not presently reported.
86	Para 4.38, p56 4.39, p56 4.40, p56 4.41, p56 4.42, p56 4.43, p56 and 57	This comment has been applied to 6 separate paragraphs. Each has been individually reviewed and commented on separately for factual accuracy as set out below.	This is inaccurate. The text needs to be reviewed and redrafted in light of the published Review of Vulnerable Persons Detained in Northern Ireland Prisons [October 2021].	This comment has been applied to 6 separate paragraphs. Each has been individually reviewed and commented on separately for factual accuracy as set out below.
87	Par 4.38, p56	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.	This is inaccurate. The text needs to be reviewed and redrafted in light of the published Review of Vulnerable Persons Detained in Northern Ireland Prisons [October 2021].	Rejected. CJI will continue to uphold its statute-based obligations as an independent Criminal Justice Inspectorate and the commentary submitted is therefore inappropriate. The commentary is also incorrect as both reviews had separate focus and were conducted

				independently from each other. The October 2021 was a '*review of services*' for vulnerable persons and not review of vulnerable persons as suggested. The Terms of Reference are clearly set out under Section 1 at paragraph 1.2 on page 8 of that report and contains no suggestion or agreement that both reports worked in collaboration or that they would reflect, agreed findings. However, of course CJI and RQIA are aware of the content and recommendations in this report. Please refer to paragraph 3.8, page 41 of *'The Review of Services for Vulnerable Persons Detained in Northern Ireland'* that clearly states, *'Coinciding with this review is Review into the Operation of Care and*

				Supervision Units in the Northern Ireland Prison Service which is jointly undertaken by CJINI in partnership with RQIA and Education and Training Inspectorate. The Terms of Reference are of notable relevance to the care and treatment of vulnerable people in custody. The Expert Review Team welcomes an in-depth review of this aspect of the service.'
88	Para 4.39, p56	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	This is inaccurate. The text needs to be reviewed and redrafted in light of the published Review of Vulnerable Persons Detained in Northern Ireland Prisons [October 2021].	Rejected. See CJI's response at point 87.

		from prison was significantly higher at 52 days.		
89	Par 4.40, p56	The percentage of patients segregated in a CSU in Northern Ireland prior to their transfer was over twice as high as that in England (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.	This is inaccurate. The text needs to be reviewed and redrafted in light of the published Review of Vulnerable Persons Detained in Northern Ireland Prisons [October 2021].	Rejected. See CJI's response at point 87.
90	Par 4.41, p56	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	This is inaccurate. The text needs to be reviewed and redrafted in light of the published Review of Vulnerable Persons Detained in Northern Ireland Prisons [October 2021].	Rejected. See CJI's response at point 87.

		units should not be used as an alternative to normal accommodation for patients with severe mental health conditions. 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.		
91	Par 4.42, p56	Data confirmed that in almost every case, patients held in Northern Ireland prisons had been transferred to hospital facilities in Northern Ireland. The current waiting arrangements in the 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.	This is inaccurate. The text needs to be reviewed and redrafted in light of the published Review of Vulnerable Persons Detained in Northern Ireland Prisons [October 2021].	Rejected. See CJI's response at point 87.
92	Par 4.43, p56 and p576	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	This is inaccurate. The text needs to be reviewed and redrafted in light of the published Review of Vulnerable Persons Detained in Northern Ireland Prisons [October 2021].	Rejected. See CJI's response at point 87.

		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.		
93	Para 4.38, p56 4.39, p56 4.40, p56 4.41, p56 4.42, p56 4.43, p56 and 57	See 6 preceeding inserted paragraphs.	NIPS was given to understand that the two review teams would collaborate re CSUs	Rejected. See CJI's response at point 87.
94	Par 4.39, p56 Entire paragraph	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	This is inaccurate and misleading. They were not being held in CSU because they were awaiting a TDO – but rather their behaviours posed a risk to staff or prisoners, including themselves.	Rejected.

		Service Benchmarking Network reported in 2019 that in England, the average waiting time to transfer from prison was significantly higher at 52 days.		
95	Par 4.40, p56 *"The percentage of patients segregated in a CSU in Northern Ireland prior to their transfer was over twice as high as that in England (16% compared with 7%)."*	The percentage of patients segregated in a CSU in Northern Ireland prior to their transfer was over twice as high as that in England (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.	The prison population in England is substantially greater than Northern Ireland and this will therefore potentially skew the figures. What is the actual number of individuals within English prisons held in the CSU prior to transfer? The Review of Vulnerable People Detained in NI Prisons stated that "*The number of forensic secure beds in Northern Ireland falls significantly below equivalent bed numbers per capita in comparison to the rest of the UK; Shannon presently offers about one third of what is required."* It is inaccurate to present this figure, without the actual numbers and without the wider context.	Footnote added to provide source of full data relating to England.
96	Par 4.42, p56 *"Data confirmed that in almost every case, patients*	Data confirmed that in almost every case, patients held in Northern Ireland prisons had been transferred to hospital facilities in Northern	Does it mean that patients in a CSU who were awaiting a TDO were transferred to hospital facilities and that those hospital facilities were in NI and not elsewhere in the	Rejected. Text changed to improve clarity.

	held in Northern Ireland prisons had been transferred to hospital facilities in Northern Ireland.	Ireland. The current waiting arrangements in the 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.	UK? This makes it sound that we use CSU as a holding facility for a TDO which is not accurate.	
97	Para 4.43, p57 *"The physical environments and facilities need to be modernised (particularly at Maghaberry and Ash House)"*	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.	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. The statement at 4.43 conflicts with the statement at 4.18	Accepted. Text amended to improve clarity on the issue identified by Inspectors and as fully explained in the report at para 4.18.
98	Par 4.44, p57 "*…the Rule 32 reviews, oversight meetings and safer custody reviews still operated in parallel…"*	Several individuals held in CSUs were also on the Prisoner Safety and Support Team (PSST) caseload in order that it could fulfil its function to support the most vulnerable prisoners in each prison.	This is inaccurate. These meetings are designed for different purposes. These meetings are designed for different purposes. A person subject to Safety & Support review may be being managed	Rejected.

	Par 4.45, p57 *"…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…"* Par 4.45, p57 *"Prisoners reported that the "goalposts" kept changing at different meetings…"*	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 CSU. Inspectors believe that prisoner outcomes will be improved by bringing these pieces of work together. 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	because of issues that were totally divorced from the reasons they are on Rule 32 and may have been on the Safety & Support case load and scheduled for review prior to them being placed on Rule 32. The Rule 32 process will then follow a routine of Rule 32 review as and when required, along with weekly Oversight. Oversight is scheduled for each Tuesday and reviews everyone on Rule 32 at that time, irrespective of whether they are due to be reviewed and possibly extended the following day. This shows that careful consideration is being given to each individual and where one approach doesn't work or cannot be facilitated, we try something different – there are no set rules or silver bullets that will work for everyone	

		"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.		
99	Para 4.51, p59 4.42, p59 4.53, p59 4.54, p59 4.55, p59 4.56, p59 4.57, p59 and p60	This comment has been applied to 7 separate paragraphs. Each has been individually reviewed and commented on separately for factual accuracy as set out below.	This is inaccurate. The CCTV recordings will only tell one part of the story – the willingness for individuals to leave their cells for example cannot be assessed via CCTV and the absence of something being recorded on paper does not mean that it did or didn't happen. Staff cannot force someone to leave their cell if they do not wish to do so and there are examples of staff going to inordinate lengths to coax individuals out of their cell, including use of Donard and Reach gardens in Maghaberry, for example, as well as at HBW and Magilligan. The timing of the field-work for example was unfortunate as given the time of year and snow/very cold weather on some days, inspectors will not have witnessed a high level of desire to use the yards for example. The key word in para 4.57 is "chose"	This comment has been applied to seven separate paragraphs. Each has been individually reviewed and commented on separately for factual accuracy as set out below.
100	Para 4.51, p59	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	This is inaccurate. The CCTV recordings will only tell one part of the story – the willingness for individuals to leave their cells for example cannot be assessed via CCTV and the absence of something being recorded on paper does not mean that it did or didn't happen. Staff cannot force someone to leave	Rejected.

		that existing arrangements failed to provide complete accurate recording methods of time spent out of cells	their cell if they do not wish to do so and there are examples of staff going to inordinate lengths to coax individuals out of their cell, including use of Donard and Reach gardens in Maghaberry, for example, as well as at HBW and Magilligan. The timing of the field-work for example was unfortunate as given the time of year and snow/very cold weather on some days, inspectors will not have witnessed a high level of desire to use the yards for example. The key word in para 4.57 is "chose"	
101	Para 4.52, p59	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.	This is inaccurate. The CCTV recordings will only tell one part of the story – the willingness for individuals to leave their cells for example cannot be assessed via CCTV and the absence of something being recorded on paper does not mean that it did or didn't happen. Staff cannot force someone to leave their cell if they do not wish to do so and there are examples of staff going to inordinate lengths to coax individuals out of their cell, including use of Donard and Reach gardens in Maghaberry, for example, as well as at HBW and Magilligan. The timing of the field-work for example was unfortunate as given the time of year and snow/very cold weather on some days, inspectors will not have witnessed a high level of desire to use the yards for example. The key word in para 4.57 is "chose"	Rejected.

102	Para 4.53, p59	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.	This is inaccurate. The CCTV recordings will only tell one part of the story – the willingness for individuals to leave their cells for example cannot be assessed via CCTV and the absence of something being recorded on paper does not mean that it did or didn't happen. Staff cannot force someone to leave their cell if they do not wish to do so and there are examples of staff going to inordinate lengths to coax individuals out of their cell, including use of Donard and Reach gardens in Maghaberry, for example, as well as at HBW and Magilligan. The timing of the field-work for example was unfortunate as given the time of year and snow/very cold weather on some days, inspectors will not have witnessed a high level of desire to use the yards for example. The key word in para 4.57 is "chose"	Rejected.
103	Para 4.54, p59	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.	This is inaccurate. The CCTV recordings will only tell one part of the story – the willingness for individuals to leave their cells for example cannot be assessed via CCTV and the absence of something being recorded on paper does not mean that it did or didn't happen. Staff cannot force someone to leave their cell if they do not wish to do so and there are examples of staff going to inordinate lengths to coax individuals out of their cell, including use of Donard and Reach gardens in Maghaberry, for example, as well as at HBW and Magilligan. The timing of the	Rejected.

			field-work for example was unfortunate as given the time of year and snow/very cold weather on some days, inspectors will not have witnessed a high level of desire to use the yards for example. The key word in para 4.57 is "chose"	
104	Para 4.55, p59	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.	This is inaccurate. The CCTV recordings will only tell one part of the story – the willingness for individuals to leave their cells for example cannot be assessed via CCTV and the absence of something being recorded on paper does not mean that it did or didn't happen. Staff cannot force someone to leave their cell if they do not wish to do so and there are examples of staff going to inordinate lengths to coax individuals out of their cell, including use of Donard and Reach gardens in Maghaberry, for example, as well as at HBW and Magilligan. The timing of the field-work for example was unfortunate as given the time of year and snow/very cold weather on some days, inspectors will not have witnessed a high level of desire to use the yards for example. The key word in para 4.57 is "chose"	Rejected.
105	Para 4.56, p59	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.	This is inaccurate. The CCTV recordings will only tell one part of the story – the willingness for individuals to leave their cells for example cannot be assessed via CCTV and the absence of something being recorded on paper does not mean that it did or didn't happen. Staff cannot force someone to leave	Rejected.

			their cell if they do not wish to do so and there are examples of staff going to inordinate lengths to coax individuals out of their cell, including use of Donard and Reach gardens in Maghaberry, for example, as well as at HBW and Magilligan. The timing of the field-work for example was unfortunate as given the time of year and snow/very cold weather on some days, inspectors will not have witnessed a high level of desire to use the yards for example. The key word in para 4.57 is "chose"	
106	Para 4.57, p59	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.	This is inaccurate. The CCTV recordings will only tell one part of the story – the willingness for individuals to leave their cells for example cannot be assessed via CCTV and the absence of something being recorded on paper does not mean that it did or didn't happen. Staff cannot force someone to leave their cell if they do not wish to do so and there are examples of staff going to inordinate lengths to coax individuals out of their cell, including use of Donard and Reach gardens in Maghaberry, for example, as well as at HBW and Magilligan. The timing of the field-work for example was unfortunate as given the time of year and snow/very cold weather on some days, inspectors will not have witnessed a high level of desire to use the yards for example. The key word in para 4.57 is "chose"	Rejected.

107	Para 4.58 , p60 *"Inspectors concluded that many prisoners were being kept locked up for long periods each day"*	4.58 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.	This is misleading. The words "kept locked up" are unfortunate as they imply that NIPS has deliberately completed this action – it does not reflect that choice that is referenced by the author in para 4.57 or of their right to make it. IT also ignores the lengths that NIPS and its partners have gone to provide activity, particularly during the pandemic. This para requires re-wording	Rejected. This comment is factually incorrect and a misrepresentation of language used in the report. There is no use of the phrase, '*kept locked up'* at 4.58 or anywhere else in the report.
108	Para 4.65, p61 Entire Paragraph	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.	This is a highly inaccurate paragraph, completely devoid of any evidence, but rather based on the anecdotal evidence and opinion of stakeholders. For such a paragraph to be included, which has the potential to destroy the morale and deeply affect staff who have recently been moved as a result of staff rotations, there must be a context and evidential standard applied to it. The paragraph is also at odds to the Vulnerable Prisoners Review which paid complimentary views towards staff.	Rejected. Positive comments have been made throughout the report.

109	Para 4.72, p63 *"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."*	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. Across the sampled six-year period, this was 61% for Catholics, which was 6% above the Catholic population for the whole prison (55%). For Protestants the figure was 28%, which was almost equal to the Protestant population for the whole prison (27%). The percentage of Catholic prisoners segregated by cellular confinement was highest at Hydebank Wood (67%) and Ash House was lowest at 49%. Table 2 provides a breakdown for all prisons.	The considerable difference in the population breakdown across the three religious groups (other, Protestant and Catholics) has not been taken into account when referring to the awards of CC and is being taken out of context. In Hydebank Wood, there are almost three times the number of Catholic males to Protestant males and almost twice as many Catholic females to Protestant females. In fact, there are as many, if not more, Catholics than the other two religious groups combined. On that basis alone it is to be expected that in every aspect of life within Hydebank Wood, there would be a higher proportion of Catholics than any of the other religious groups. The embedded document below contains a full breakdown of statistics and analysis.  Document2.docx	Rejected. Section reviewed - Table repositioned and data appropriately updated to maintain accuracy of this section.

McVeigh, Meloney

From: McVeigh, Meloney
Sent: 24 January 2022 14:31
To: [redacted]
Subject: CSU Draft PR
Attachments: DRAFT EXEC MEDIA RELEASE -CSU 24.01.22.docx

Importance: High

Tracking:

Recipient	Delivery	Read
[redacted]	Delivered: 24/01/2022 14:31	Read: 24/01/2022 14:36

HI [redacted]
Please find attached a copy of the draft PR for the CSU report. Grateful if you could share/discuss with NIPS and come back to me as soon as possible or by lunchtime on Wednesday at the latest. I'll give you a call tomorrow to discuss re plans from both our sides if that suits. I'm awaiting a final copy of the report back from our designers - I will send that it through for info once I get it. Happy to chat anytime.
Meloney

Meloney McVeigh
Business and Communications Manager

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Criminal Justice Inspection
Northern Ireland
a better justice system for all

PRESS RELEASE

Strictly under embargo until xxxxhrs, 1 February 2022 (RELEASE DETAILS TBC)

Independent review finds some prisoners in Care and Supervision Units experiencing regimes amounting to solitary confinement

An independent review of the operation of Care and Supervision Units in the Northern Ireland Prison Service (NIPS) led by Criminal Justice Inspection Northern Ireland (CJI) has found some prisoners held there experienced regimes which amounted to solitary confinement and their treatment did not meet the expected United Nations (UN) Standard Minimum Rules.

The Chief Inspector of Criminal Justice in Northern Ireland, Jacqui Durkin agreed to undertake the focused review in partnership with Inspectors from the Regulation and Quality Improvement Authority, Education, and Training Inspectorate in November 2020 after significant concerns were raised with the Minister of Justice about the operation of the units in Northern Ireland's prisons.

"Prisoners can be segregated in Care and Supervision Units (CSUs) away from the general prison population for their own safety or the safety of others, for breaking Prison Rules or because they are suspected of having drugs or other illicit items in their possession. Some prisoners placed in the CSUs have severe mental disorders and individual needs that make them more vulnerable, complex and particularly challenging for staff to care for," said Ms Durkin.

"However regardless of why any male or female prisoner is segregated in a CSU, there are accepted *Expectations* developed by Her Majesty's Inspectorate of Prisons in England and Wales (HMIP) and UN Standard Minimum Rules for their treatment and care that apply, which include access to health care and purposeful activity, like learning, skills and physical activity.

"This in-depth review found evidence that the regime experienced by a number of CSU prisoners did not meet the UN Standard Minimum Rules known as the *Mandela Rules*. We found evidence that prisoners in CSUs were spending too long in their cell without meaningful human contact," said the Chief Inspector.

She continued: "During our work Inspectors met impressive and committed Prison Officers and health care staff in CSUs who demonstrated compassion for the prisoners and patients in their care while facing complex challenges every day and I commend them all for their efforts.

"But I believe that without appropriate evidence, it is not possible to provide satisfactory assurance to prisoners and their families, the Minister of Justice, the Northern Ireland Assembly or the wider community, that prisoners held in CSUs in Northern Ireland's prisons experienced a regime that met required minimum standards for the treatment of prisoners," said Ms Durkin.

Inspectors found meaningful human contact and interactions with prisoners were not sufficiently evidenced or recorded to dispel wider concerns about the length of time prisoners spent in their cells.

"For contact to be 'meaningful' it must extend beyond meeting a prisoner's basic needs such as providing a food tray at a door, asking if they had any requests or wanted a shower," said Ms Durkin.

"Establishing and maintaining meaningful human contact with prisoners who do not, or cannot, engage can be extremely challenging. It requires skilled, motivated staff with access to support and specialist advice when needed."

Inspectors found opportunities for prisoners held in the CSUs to participate in purposeful activity, including learning and skills and physical activity, were not proactively encouraged and association with other prisoners was not routinely assessed or provided.

Staff were hindered by the limitations of the present facilities and the Inspection Team identified a clear need for Prison Officers to be supported with appropriate staff selection procedures and training to improve prisoner outcomes.

Ms Durkin said that despite the NIPS's promotion of a corporate ethos of prisoners being treated as *'people in our care,'* it did not have a strategy in place for the operation and future development of CSUs where some of the most vulnerable people in the prison system live.

"The lack of a clearly defined corporate approach for CSUs – that is promoted by the NIPS leadership and supports the implementation and delivery of consistent, operational practice in each CSU - has hampered opportunities to improve outcomes for segregated prisoners," said the Chief Inspector.

Inspectors also found the shared CSU for young men and women at Hydebank Wood in place at the time of fieldwork was undertaken was out of step with the UN *Mandela Rules* and HMIP's specific *Expectations* for women in prison as it did not provide 'entirely separate' facilities.

Inspectors have made three strategic and 11 operational recommendations for improvement as a result of their findings.

"I believe these recommendations will help ensure UN Standard Minimum Rules for the treatment and care of segregated prisoners are met and deliver improvements in oversight and operational prison practice, health care provision, education and training opportunities and outcomes for prisoners" said Ms Durkin.

"I acknowledge the messages in the review report are hard for many involved in the care of prisoners to hear, particularly given the efforts made by the NIPS to keep prisoners safe from the COVID-19 virus during the pandemic and the focus there has been on managing its impact on staff and services. However, the issues we identified existed before, were present during and will extend beyond the pandemic unless action is taken on the recommendations," said Ms Durkin.

"I am pleased the NIPS has accepted the review report recommendations and I expect the Director General and his leadership team, working with the Department of Justice, and its partners in the South Eastern Health and Social Care Trust and Belfast Metropolitan College, will specifically reflect them in its future plans and priorities to improve prisoner outcomes.

"I will be maintaining a focus on the issues identified in this review report when we follow-up on the implementation of the recommendations as part of future prison inspections we undertake with our Inspection partners," concluded the Chief Inspector.

ENDS

Notes for editors

- An advance copy of the Review Report into the Operation of CSUs by the NIPS can be viewed by following the link. Following the publication the review report can be viewed or downloaded from the CJI website.
- On-site fieldwork within each of Northern Ireland's three CSUs took place over a three-week period in January and February 2021.
- As part of the in-depth review, Inspectors examined policies and procedures relating to the operation of the CSUs, paper and electronic records, journals, CCTV and body-worn camera footage and spoke with staff at all levels within the NIPS and Prison Officers and health care staff at working in the CSUs.

Inspectors also spoke to prisoners held in the CSU at the time of the inspection fieldwork and those who previously held in a CSU about their treatment and experience. Inspectors also engaged with stakeholders from the voluntary and community sector.

- A review of the draft report was undertaken by Inspectors from Her Majesty's Inspectorate of Prisons in England and Wales.
- Rule 44 of the UN Standard Minimum Rules (Mandela Rules) defines solitary confinement as: "*The confinement of prisoners for 22 hours or more a day without meaningful human contact.*"
- Analysis of a sample of CCTV footage from each CSU facility viewed by Inspectors showed the average time spent out of cell for CSU prisoners in Maghaberry over a five-day period was 25 minutes per day; at Magilligan over a three-day period it was 26 minutes per day and at Hydebank over a three-day period it was 89 minutes per day.
- **For further information or to obtain an interview with the Chief Inspector of Criminal Justice, Jacqui Durkin, please contact Meloney McVeigh, Communications Manager on 0772 558 1835.**

Notes ends

McVeigh, Meloney

From: McVeigh, Meloney
Sent: 26 January 2022 09:25
To: [redacted]
Subject: DRAFT EXEC MEDIA RELEASE -CSU 25.01.22
Attachments: DRAFT EXEC MEDIA RELEASE -CSU 25.01.22.docx

Morning [redacted],
I've attached a revised version of the pr referencing the request by the Minster for CJI to undertake the CSU work on par 2 as we discussed yesterday.
Good to speak to you yesterday. I'll keep in touch.

Thanks Meloney

Criminal Justice Inspection
Northern Ireland
a better justice system for all

PRESS RELEASE

Strictly under embargo until xxxxhrs, 1 February 2022 (RELEASE DETAILS TBC)

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"Prisoners can be segregated in Care and Supervision Units (CSUs) away from the general prison population for their own safety or the safety of others, for breaking Prison Rules or because they are suspected of having drugs or other illicit items in their possession. Some prisoners placed in the CSUs have severe mental disorders and individual needs that make them more vulnerable, complex and particularly challenging for staff to care for," said Ms Durkin.

"However regardless of why any male or female prisoner is segregated in a CSU, there are accepted *Expectations* developed by Her Majesty's Inspectorate of Prisons in England and Wales (HMIP) and UN Standard Minimum Rules for their treatment and care that apply, which include access to health care and purposeful activity, like learning, skills and physical activity.

"This in-depth review found evidence that the regime experienced by a number of CSU prisoners did not meet the UN Standard Minimum Rules known as the *Mandela Rules*. We found evidence that prisoners in CSUs were spending too long in their cell without meaningful human contact," said the Chief Inspector.

She continued: "During our work Inspectors met impressive and committed Prison Officers and health care staff in CSUs who demonstrated compassion for the prisoners and patients in their care while facing complex challenges every day and I commend them all for their efforts.

"But I believe that without appropriate evidence, it is not possible to provide satisfactory assurance to prisoners and their families, the Minister of Justice, the Northern Ireland Assembly or the wider community, that prisoners held in CSUs in Northern Ireland's prisons experienced a regime that met required minimum standards for the treatment of prisoners," said Ms Durkin.

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Inspectors also found the shared CSU for young men and women at Hydebank Wood in place at the time of fieldwork was undertaken was out of step with the UN *Mandela Rules* and HMIP's specific *Expectations* for women in prison as it did not provide 'entirely separate' facilities.

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"I will be maintaining a focus on the issues identified in this review report when we follow-up on the implementation of the recommendations as part of future prison inspections we undertake with our Inspection partners," concluded the Chief Inspector.

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- **For further information or to obtain an interview with the Chief Inspector of Criminal Justice, Jacqui Durkin, please contact Meloney McVeigh, Communications Manager on 0772 558 1835.**

Notes ends

McVeigh, Meloney

From: McVeigh, Meloney
Sent: 26 January 2022 14:07
To: [redacted]
Subject: FW: Par 2 DRAFT EXEC MEDIA RELEASE -CSU 25.01.22
Attachments: DRAFT EXEC MEDIA RELEASE -CSU 25.01.22.docx

Importance: High

Hi [redacted],

Sorry – further slight tweak at my side to par 2 to clarify the timeline for how the review came abou tbut it doesn't alter the point you wanted to have around the Minister making the request for the work to be carried out. See below.
Many thanks Meloney.

The Chief Inspector of Criminal Justice in Northern Ireland, Jacqui Durkin agreed to undertake the focused review following a request from the Minister of Justice in November 2020 after significant concerns were raised with the Minister about the operation of the units in Northern Ireland's prisons. It was carried out in partnership with Inspectors from the Regulation and Quality Improvement Authority and the Education and Training Inspectorate.

From: McVeigh, Meloney
Sent: 26 January 2022 09:25
To: [redacted]@justice-ni.gov.uk>
Subject: DRAFT EXEC MEDIA RELEASE -CSU 25.01.22

Morning [redacted],
I've attached a revised version of the pr referencing the request by the Minster for CJI to undertake the CSU work on par 2 as we discussed yesterday.
Good to speak to you yesterday. I'll keep in touch.

Thanks Meloney

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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
a better justice system for all

national preventive mechanism

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

February 2022

Laid before the Northern Ireland Assembly under Section 49(2) of the Justice (Northern Ireland) Act 2002 (as amended by paragraph 7(2) of Schedule 13 to The Northern Ireland Act 1998 (Devolution of Policing and Justice Functions) Order 2010) by the Department of Justice.

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

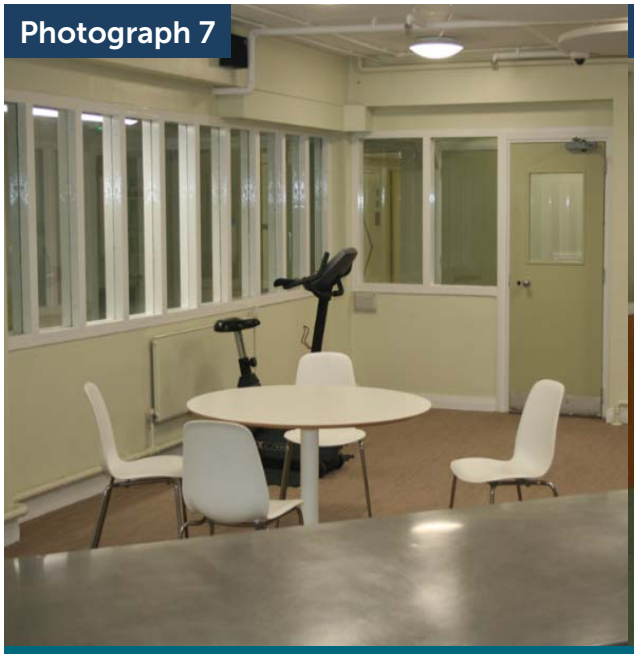
3.9 Prisoners in all cells in all CSUs had 24-hour access to the Samaritans. There were restrictions on the amount of personal property that prisoners were permitted in their cells. At Maghaberry, items not permitted in the cell were placed outside the cell door and prisoners could request access to 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.

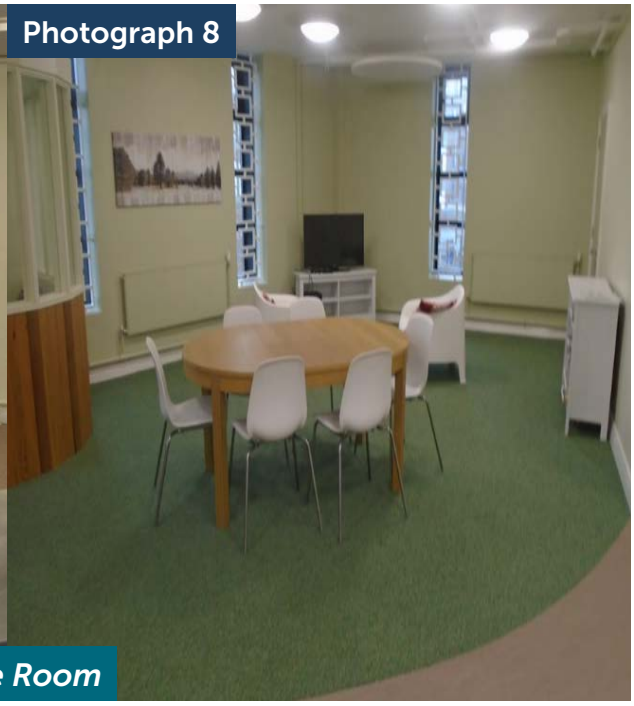
3.11 Unlike normal residential units/areas, there were no communal rooms or areas for dining, associating with other prisoners or classrooms within the CSUs at Maghaberry and Magilligan. There were limited interview rooms to facilitate one to one discussions with prisoners. This issue was raised with 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.

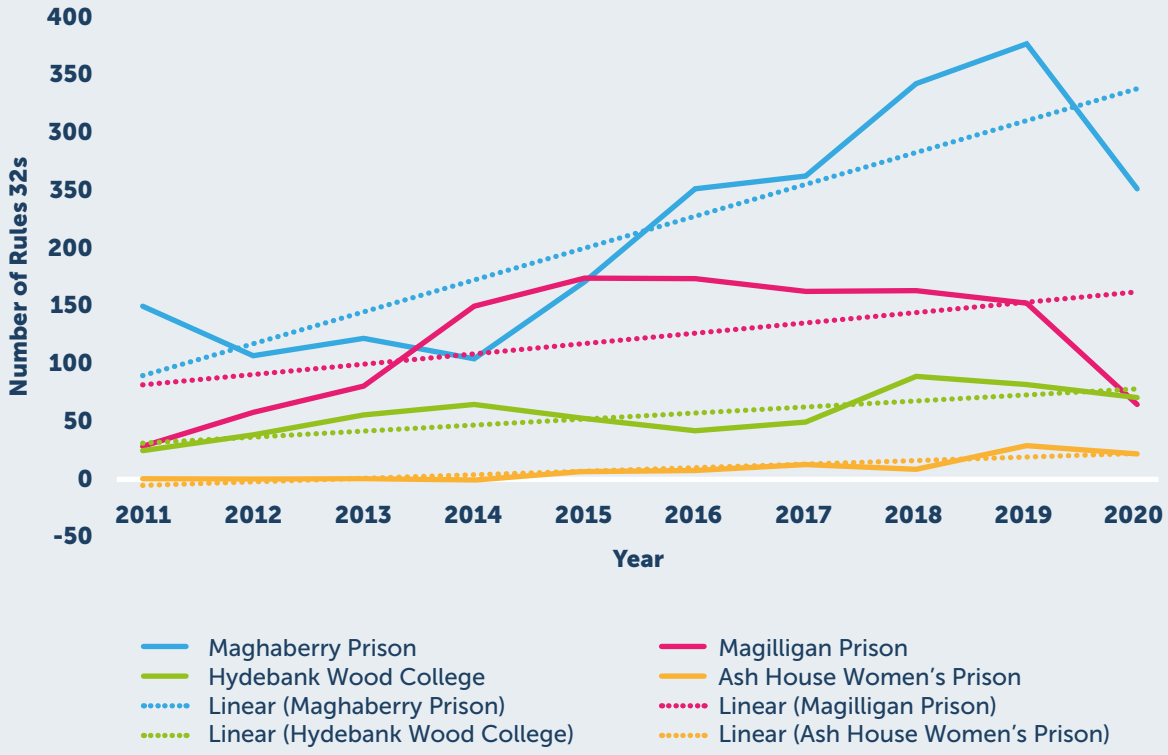
12 The following data was provided by the NIPS. For the period 2011 to 2020 at Maghaberry the average daily population of the CSU was 19 and the average daily prison population was 937. At Magilligan the average daily population of the CSU was seven and the average daily prison population was 486. At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

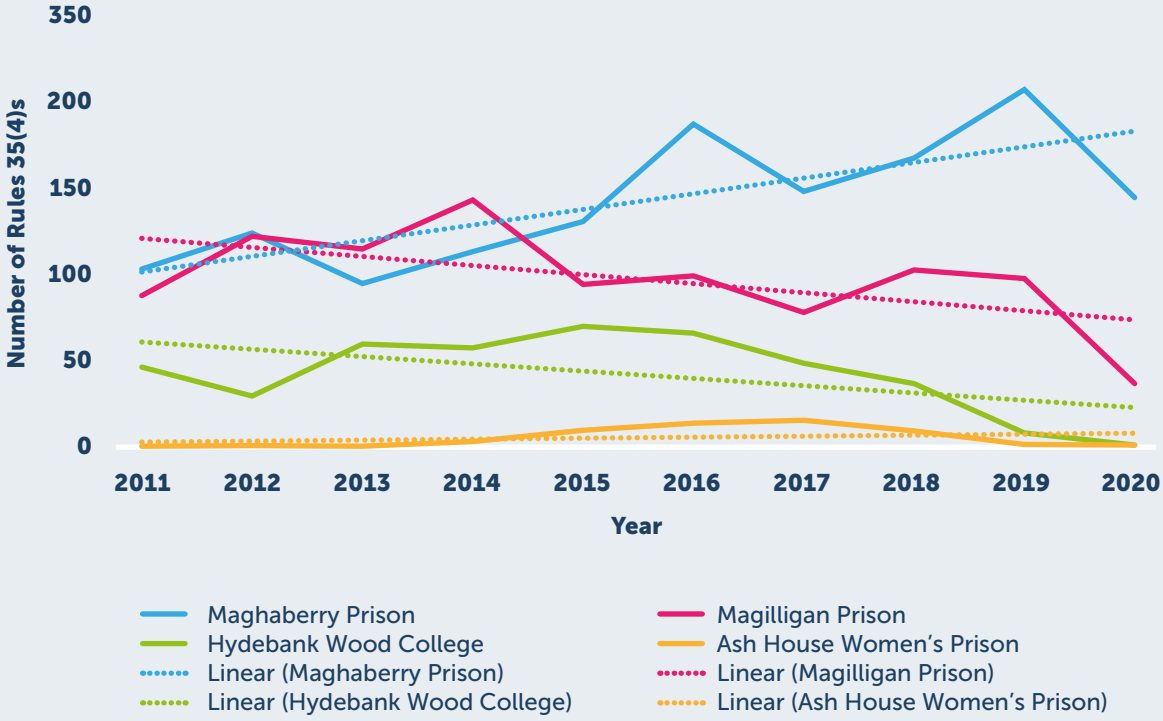
3.24 Dry cells were unique to Maghaberry CSU and provided the most basic accommodation in the CSU. From 2015 the average duration of stays in dry cells at Maghaberry was three days, but there were individual examples of prisoners spending excessively long periods in dry cells. In 2020, some prisoners 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)



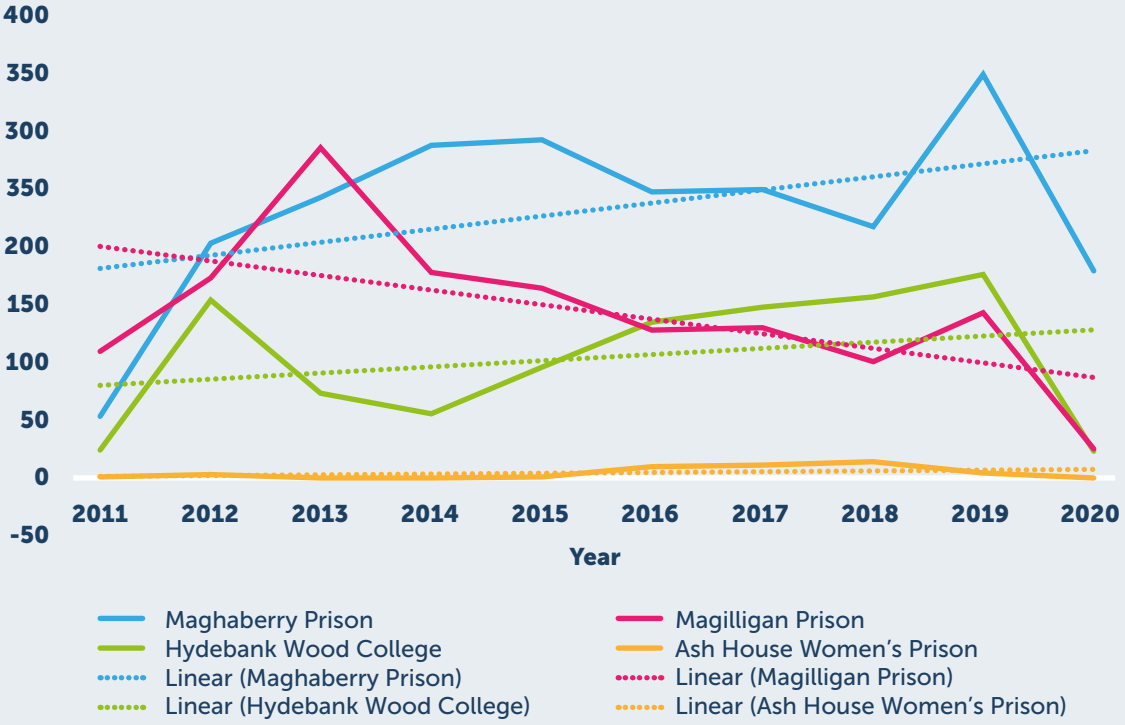
Use of cellular confinement

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).

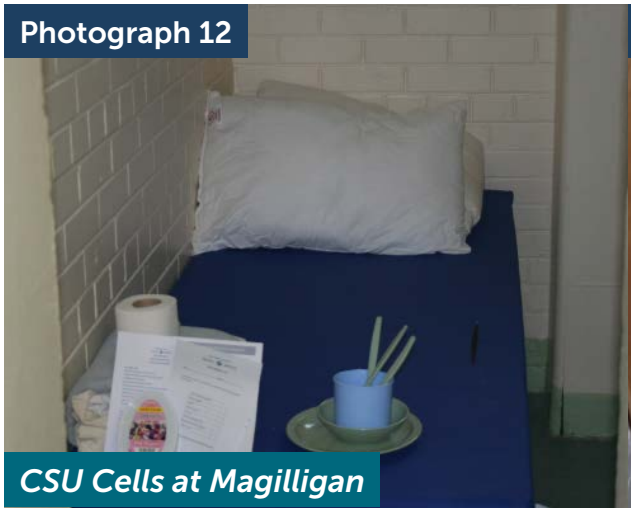
REGIME AND PURPOSEFUL ACTIVITY

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.

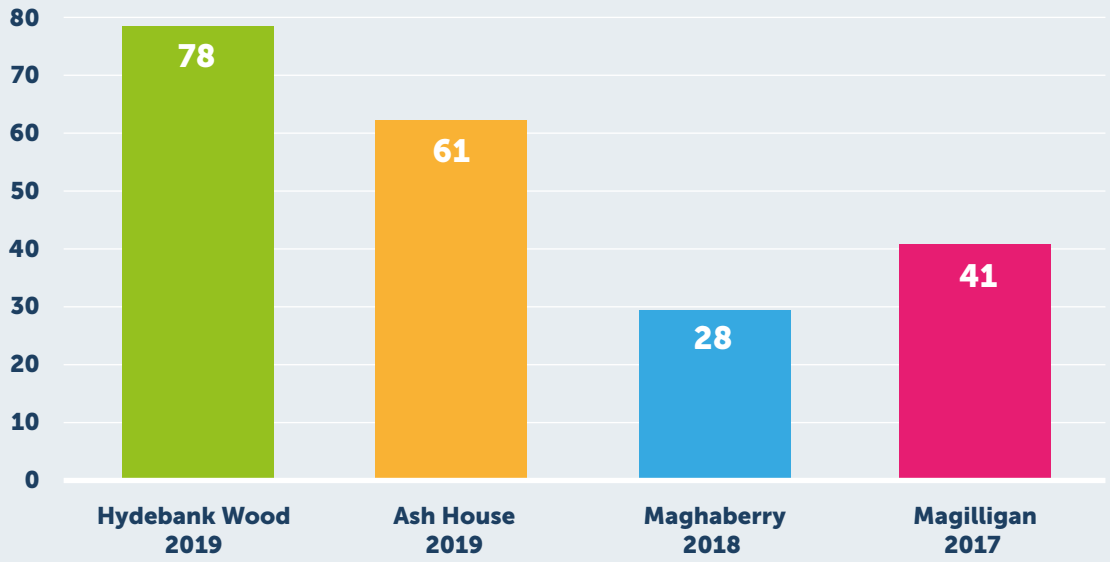
4.58 A lack of detailed recording of routine interactions with prisoners made it extremely difficult to assess the level of meaningful contact between prisoners and others. Most prisoners said they had very little contact with staff outside the routine visits for requests, meals, or Governor visits. 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.

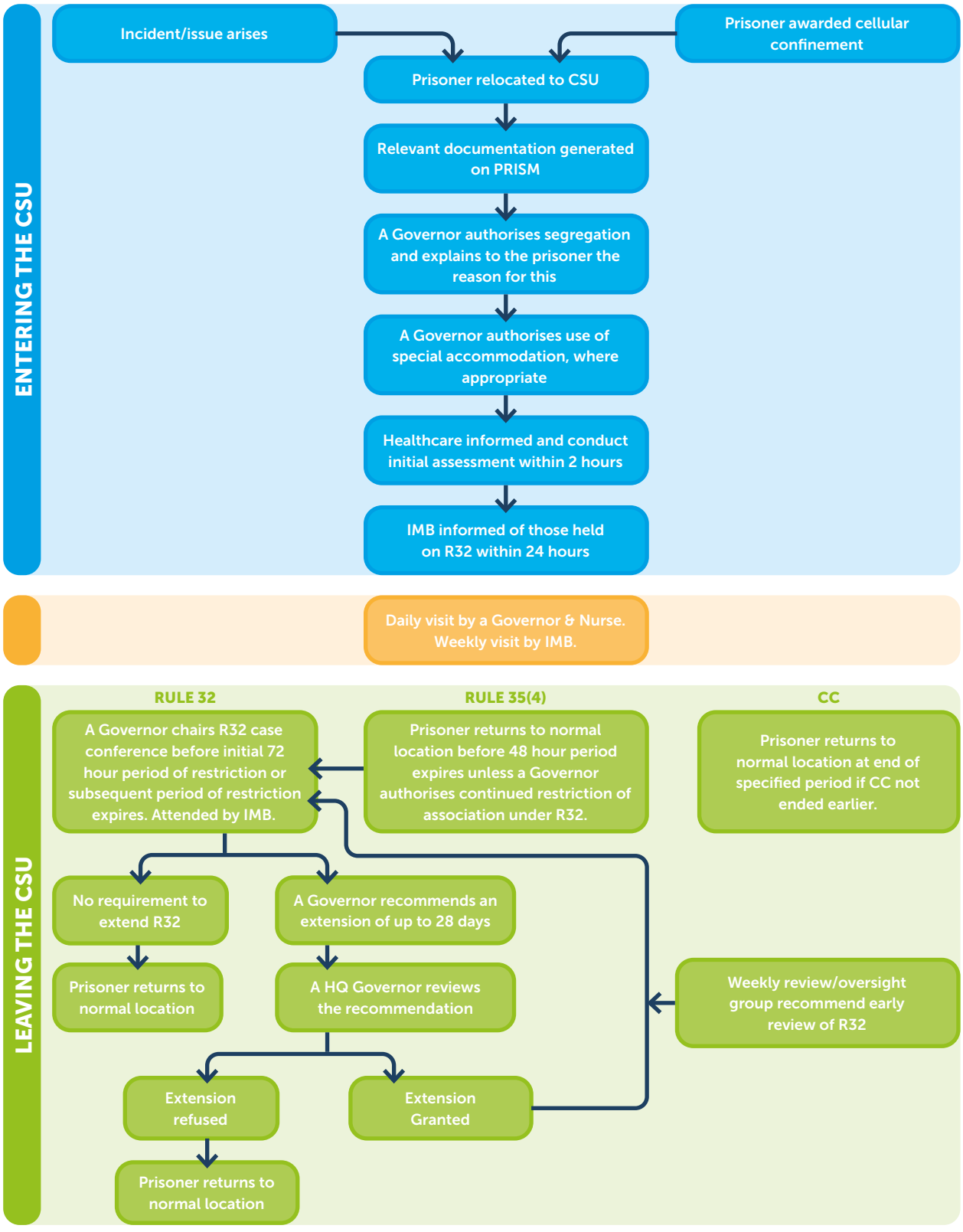
Indicators

- 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.

Criminal Justice Inspection
Northern Ireland
a better justice system for all

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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
a better justice system for all

national preventive mechanism

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

February 2022

Laid before the Northern Ireland Assembly under Section 49(2) of the Justice (Northern Ireland) Act 2002 (as amended by paragraph 7(2) of Schedule 13 to The Northern Ireland Act 1998 (Devolution of Policing and Justice Functions) Order 2010) by the Department of Justice.

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**

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.

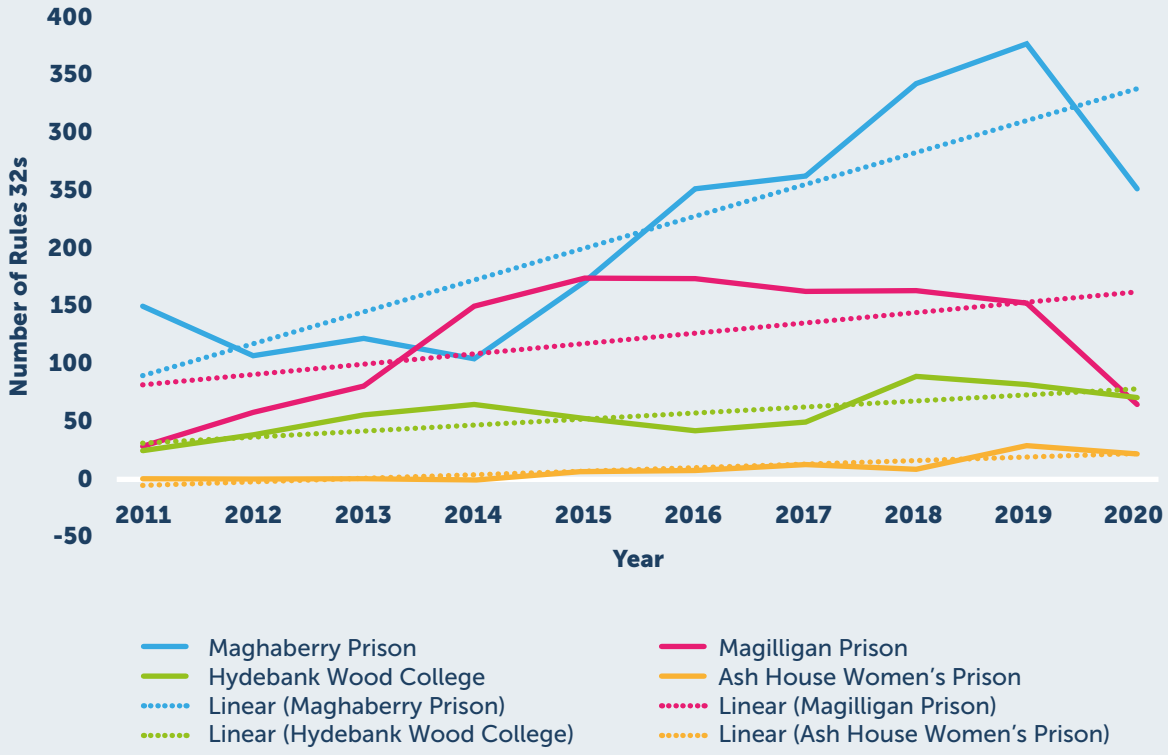
12 The following data was provided by the NIPS. For the period 2011 to 2020 at Maghaberry the average daily population of the CSU was 19 and the average daily prison population was 937. At Magilligan the average daily population of the CSU was seven and the average daily prison population was 486. At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

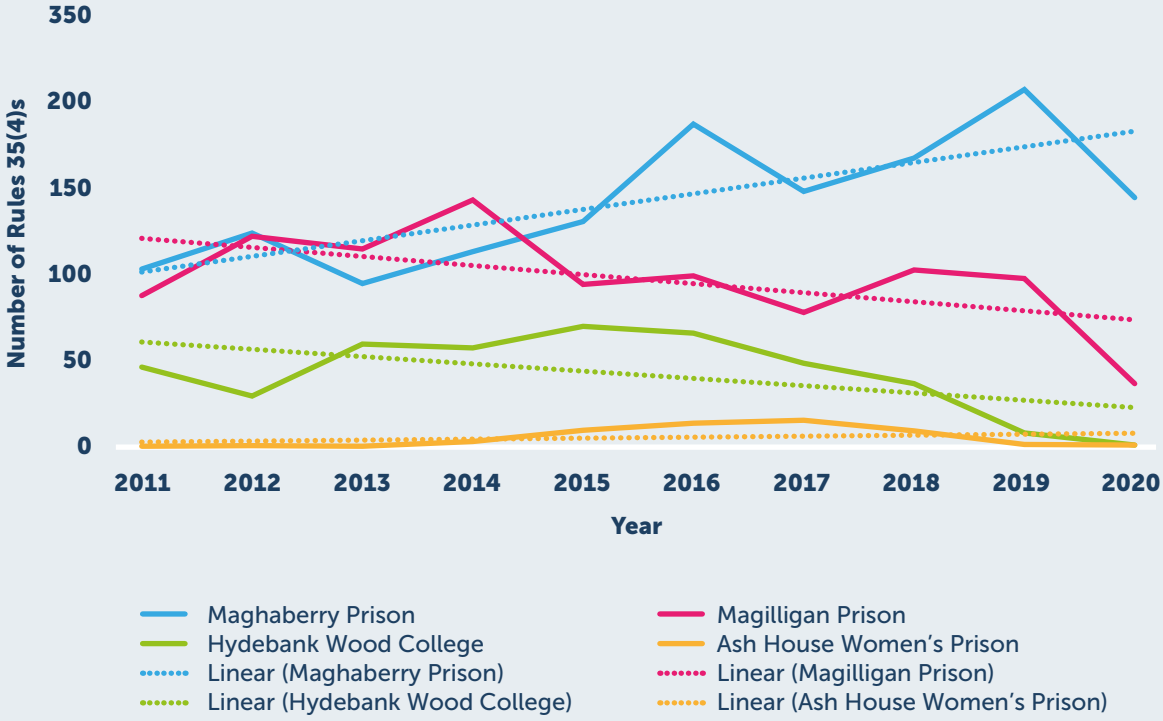
3.24 Dry cells were unique to Maghaberry CSU and provided the most basic accommodation in the CSU. From 2015 the average duration of stays in dry cells at Maghaberry was three days, but there were individual examples of prisoners spending excessively long periods in dry cells. In 2020, some prisoners 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)



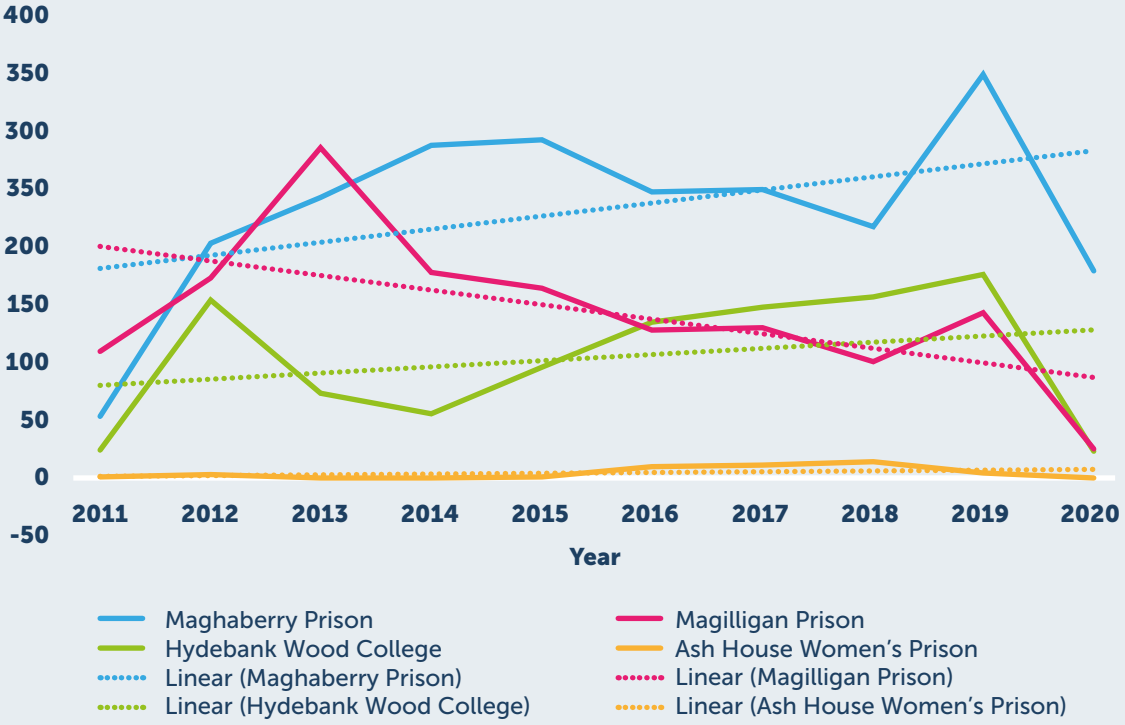
Use of cellular confinement

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).

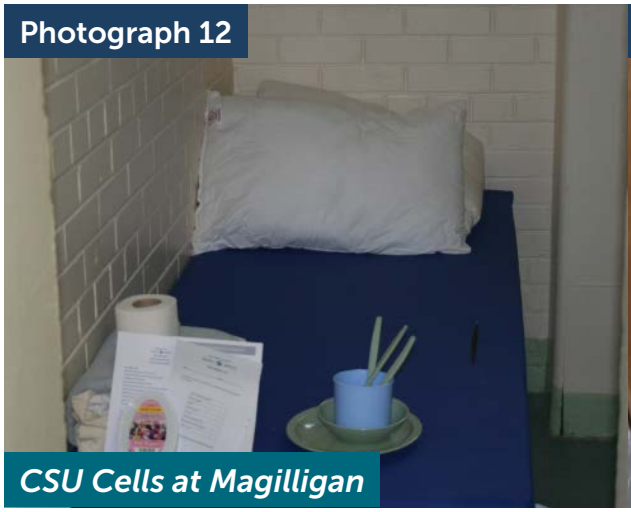
REGIME AND PURPOSEFUL ACTIVITY

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.

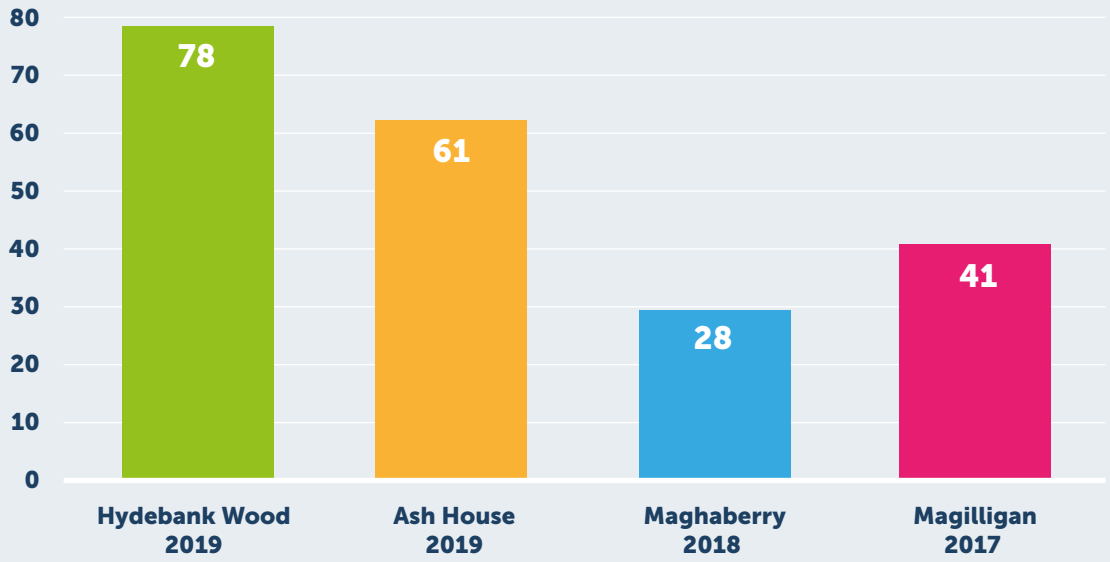
4.58 A lack of detailed recording of routine interactions with prisoners made it extremely difficult to assess the level of meaningful contact between prisoners and others. Most prisoners said they had very little contact with staff outside the routine visits for requests, meals, or Governor visits. 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 15 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.

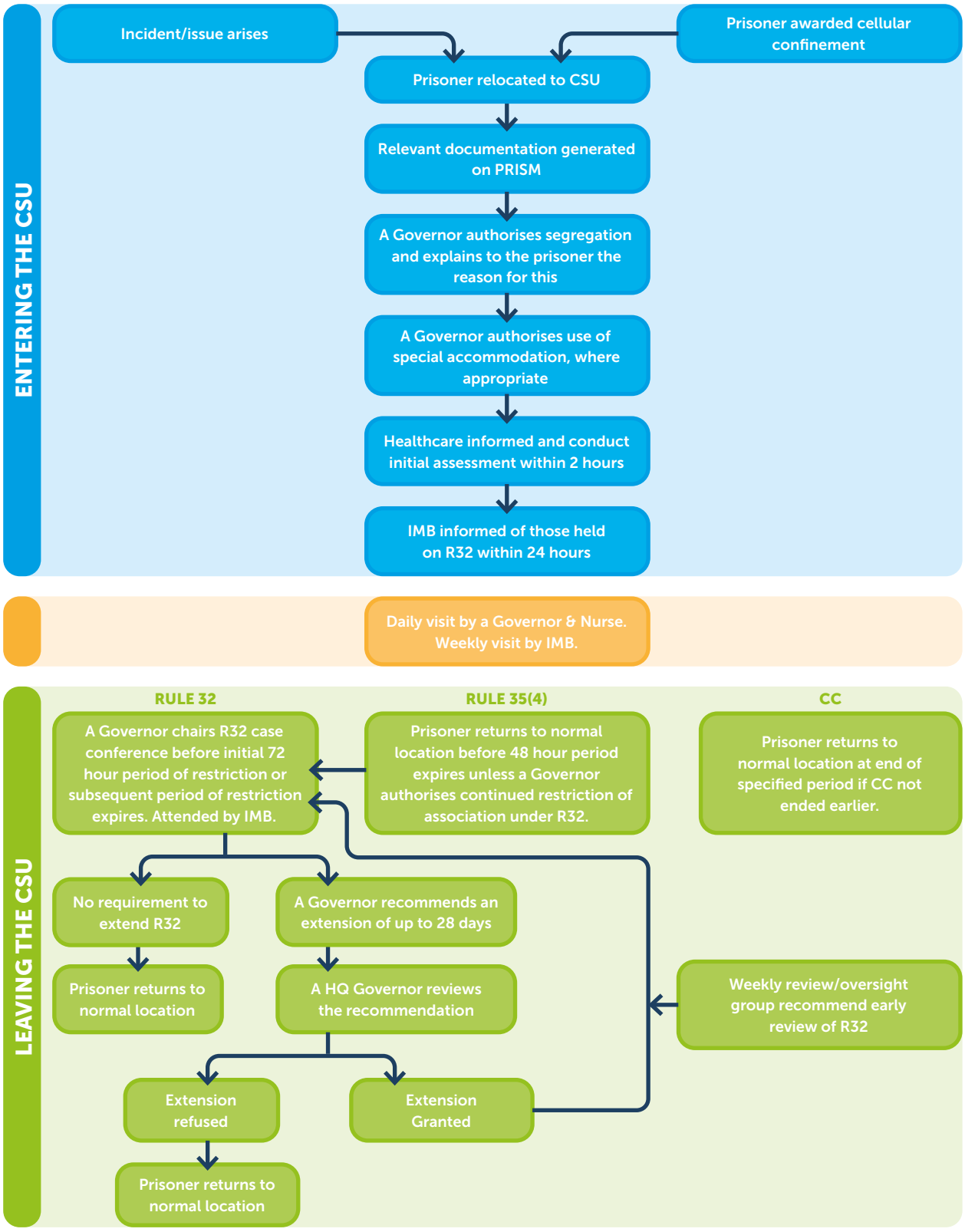
Indicators

- 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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