Vulnerable Prisoners

An inspection of the treatment of vulnerable prisoners by the Northern Ireland Prison Service

December 2009

Criminal Justice Inspection
Northern Ireland
a better justice system for all

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Presented to the Houses of Parliament by the Secretary of State for Northern Ireland under Section 49 (2) of the Justice (Northern Ireland) Act 2002.

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Contents

List of abbreviations

ASIST	Applied Suicide Intervention Skills Training
CJI	Criminal Justice Inspection Northern Ireland
DSPD	Dangerous and Severe Personality Disorder
HMIP	Her Majesty's Inspectorate of Prisons in England and Wales
NCO	Night Custody Officer
NIPS	Northern Ireland Prison Service
PAR 1	Prisoner at Risk process/document
POA	Prison Officers' Association
PRISM	Prison Record and Inmate System Management (IT System)
PSMB	Prison Service Management Board
PSNI	Police Service of Northern Ireland
REACH	Reaching out through Engagement, Assessment, Collaborative working and Holistic approach
SEHSCT	South Eastern Health and Social Care Trust
SMART	Specific, Measurable, Achievable, Realistic and Time-bound
SPAR	Supporting Prisoners At Risk process/document
SSU	Special Supervision Unit
YJA	Youth Justice Agency
YOC	Hydebank Wood Young Offenders' Centre

Chief Inspector's Foreword

Prisons by their very nature are not therapeutic environments. Yet they have to deal with some very disturbed and dangerous individuals who present a risk both to themselves and others. Despite this difficulty there is a duty of care on the Northern Ireland Prison Service (NIPS) to provide safe, humane conditions and a therapeutic approach to prisoners in their care. There is an expectation that individuals who present with problems will be looked after appropriately. While the overall rates for death in custody in Northern Ireland are not significantly higher than elsewhere in the United Kingdom, an investigation following the death of Colin Bell on 1 August 2008 highlighted a number of serious inadequacies in the prison regime.

This inspection presents Criminal Justice Inspection Northern Ireland's (CJI's) assessment of the treatment of vulnerable prisoners by the NIPS. It was undertaken during July and August 2009 – six months after the publication of the Northern Ireland Prisoner Ombudsman's Report (one year after the death of Colin Bell) and six months after the joint CJI/Her Majesty's Inspectorate of Prisons (HMIP) unannounced inspection of Maghaberry Prison, which highlighted a significant number of issues in relation to the safety of prisoners there.

This inspection report sets out CJI's assessment of the extent to which the recommendations made in the Prisoner Ombudsman's Report of January 2009 have been delivered. It also provides a wider view on the treatment of vulnerable prisoners across the NIPS. Our assessment is that much activity has taken place in response to the Prisoner Ombudsman's Report. The NIPS has worked hard to ensure that the operational service failures and negligence identified following the death of Colin Bell will not be repeated in further deaths in custody. We found examples of good practice across the NIPS and many committed staff.

In spite of this activity, there remains a significant concern over the regime for vulnerable prisoners at Maghaberry Prison. Maghaberry Prison has the highest proportion of prisoners at risk within the system. While Inspectors saw significant evidence of awareness among staff of the risks associated with the care of vulnerable prisoners, little appeared to have changed in the regime for prisoners since the January 2009 inspection conducted by CJI and HMIP. By this we mean that the day-to-day regime for vulnerable prisoners is not adequate for their on-going care and improvement. Prisoners continue to spend too long in their cells, have inadequate multi-disciplinary care and limited access to out-of-cell activities. The assessment and monitoring of prisoners at risk is also inconsistent.

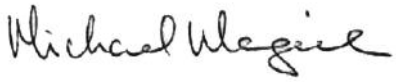
This is despite the stated intention of the NIPS and the South Eastern Health and Social Care Trust (SEHSCT) to improve the regime for vulnerable prisoners through the development of the REACH landing and the priority given to the issue throughout 2009. There remained – at the time of this inspection – a continued disconnect between the stated intention of the NIPS in relation to vulnerable prisoners and activities on the ground.

Many of these problems stem from the environment within which Maghaberry Prison operates. Inspectors found for example, that regardless of the priority given to vulnerable prisoners within the prison, the REACH landing still had to fight for resources that were being re-allocated to other parts of Maghaberry Prison. This is in an organisation that has a high prisoner to staff ratio when compared with other establishments. We also found that prisoner/staff interaction was poor and good practice was too often dependent on individuals who wanted to make a difference rather than the norm.

The continued disconnect between the stated intention of management and the delivery of real and meaningful outcomes for prisoners continues to raise significant concerns. Certainly there is evidence that the current industrial relations climate, culture and behaviour of staff are not conducive to promoting a culture of care and accountability.

This inspection shows that the NIPS has attempted to address many of the immediate issues surrounding the tragic death of Colin Bell. It is important that this is viewed as a starting point rather than the end of the process, if further deaths in custody are to be prevented and the care of vulnerable prisoners is to be improved.

The inspection was carried out by Tom McGonigle and Dr Ian Cameron. I would take this opportunity to express my thanks to the Inspection Team and all those who participated in the inspection.



Dr Michael Maguire
Chief Inspector of Criminal Justice in Northern Ireland

December 2009

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Executive Summary

The primary objective of this inspection was to assess the progress of the Northern Ireland Prison Service (NIPS) in implementing the Northern Ireland Prisoner Ombudsman's recommendations since January 2009, following her report into the death of Colin Bell at Maghaberry Prison. It also took account of previous inspection findings relevant to safer custody.

Our main finding is that while the NIPS has worked hard and delivered the *letter* of many recommendations, it has still considerable scope for progress in relation to implementing their *spirit*. While we conclude that most of the Prisoner Ombudsman's recommendations had been implemented, the minority that had not been implemented were some of the most critical. Most progress had been made in relation to 'policy' initiatives (issuing instructions/reminders to staff, providing physical equipment and making structural amendments) – 66% achieved – compared with 39% of 'operational' issues. The regime provided for vulnerable prisoners remained unduly limited.

Inspectors found that procedural improvements did not translate into meaningful outcomes from the perspective of vulnerable prisoners, and there remain significant concerns around the provision of a suitable regime in each establishment, particularly in Maghaberry Prison. A wide range of activities such as remedial education, work and social interaction, is recognised as essential for helping vulnerable prisoners to cope. However, as reported in previous inspections, these were still in too short supply and out-of-cell time was much less than would be expected.

Population pressures and a lack of priority for Maghaberry Prison's Reaching out to prisoners through Engagement, Assessment, Collaborative working and Holistic approach (REACH) landing, thwarted the original concept of its function as a dedicated landing for vulnerable prisoners with specialist inter-disciplinary staff and a therapeutic regime.

Vulnerable prisoners could display a variety of personality characteristics, and some who had aggressive traits or mental illness were very difficult to manage. Inspectors found the NIPS was better at providing safe custody for compliant prisoners than for disruptive prisoners.

Perhaps the best example of improved practice was the activity of newly-appointed safer custody personnel. They were proactively taking a range of initiatives involving prisoners in meetings, auditing documentation and providing feedback to staff, as well as establishing prisoner fora. The NIPS had appointed some very good staff to the safer custody roles and it is imperative that these posts remain ring-fenced.

Management information had improved considerably with the advent of the Prison Record and Inmate System Management (PRISM) information technology system. Certain features of PRISM required adjustment to ensure the data was accurate, and it still needed to be used more proactively by managers. If fully implemented, the new Supporting Prisoners At Risk

(SPAR) process and proposed dispersal of prisoners to Magilligan Prison should also enhance delivery of safer custody.

Inspectors found there had been a flurry of activity since January 2009 and all NIPS staff had undoubtedly been given the message that the levels of negligence revealed in relation to Colin Bell's death must never be repeated. While progress commenced promptly in Magilligan Prison and Hydebank Wood Young Offenders Centre (YOC), progress at Maghaberry Prison, where the need was greatest, had been slower in starting.

There remained a disconnect between official NIPS policy on safer custody and activity on the ground. The core regime for vulnerable prisoners was also impacted upon negatively by wider management pressures. These included:

- NIPS priorities meant safer custody was downgraded when other matters were deemed higher priority. For example since October 2006 the Headquarters-based Safer Custody Governor was transferred to other duties on three occasions for lengthy periods;
- the framework agreement between the NIPS and the Prison Officers' Association (POA) in relation to the allocation of staff made many aspects of prison life, including safer custody, very difficult to manage;
- industrial action by POA members between January and July 2009 provided an additional impediment to regime delivery for all prisoners; and
- violence reduction/anti-bullying, an essential component of safer custody, had not received sufficient attention due to the emphasis on suicide prevention.

Inspectors met some excellent and committed staff who were making a difference, but it was too often on the basis of individual interest rather than within a corporate framework, and a therapeutic approach was not ingrained. Cynical attitudes remained and there was an overriding security focus with certain staff remaining reluctant to engage with prisoners.

Once again we find it necessary to identify insufficient psychology input into an aspect of Maghaberry Prison life – safer custody in this instance. While this now is a matter for the South Eastern Heath and Social Care Trust (SEHSCT), it is important that corrective action is taken.

Safer custody has undoubtedly been a 2009 priority for the NIPS. The challenge will be to retain this focus when other priorities intervene. Specific attention needs to be devoted to implementation of the women's strategy and to the juvenile population at the YOC.

There are 10 recommendations included in this report because we do not wish to restate recommendations that have been made elsewhere. However, we make specific comment about the NIPS's capacity to manage inspection Action Plans and remind the NIPS that many previous recommendations still require attention.

Safer custody will remain an integral element of future announced and unannounced prison inspections. CJI will return in early 2010 to seek reassurance in respect of several important matters, flagged up in the body of the report, that were outstanding at the conclusion of the inspection.

Recommendations

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

- **The NIPS review and strengthen its capacity for more critical self-appraisal and recommendations should be followed by SMART Action Plans *(paragraph 3.6)*.**

- **The NIPS should by January 2010 revise its safer custody meeting structure to clarify participation and input expectations, differentiate between strategic and operational agendas and train staff in focusing on *outcomes* rather than *actions (paragraph 3.17)*.**

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

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

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

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

- **Maghaberry Prison should establish a prisoner forum *(paragraph 4.19)*.**

- **The NIPS should set targets for increasing the numbers of Listeners in each establishment and produce an Action Plan to improve their deployment *(paragraph 4.22)*.**

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

Section 1

Inspection Report

CHAPTER 1:

Introduction

Context

1.1 This inspection report follows on from a series of previous investigations that have considered the treatment of vulnerable prisoners by the Northern Ireland Prison Service (NIPS). They include:

- previous inspection findings in relation to suicide and self-harm at each of the four NIPS establishments;
- the Northern Ireland Prisoner Ombudsman's report into the death of Colin Bell, published in January 2009. The NIPS had received an interim report in September 2008 and it brought glaring deficiencies into sharp focus;
- the McClelland Review of six non-natural deaths in prison custody in Northern Ireland between June 2002 and March 2004 (published in January 2006);
- the Pearson Review pursuant to the death in custody of Colin Bell on 1 August 2008, published in June 2009; and
- ongoing deliberations of the Ministerial Forum on Safer Custody which was established in January 2009.

Scope of the inspection

1.2 There is no standard definition of a 'vulnerable prisoner' available. Indeed all persons in lawful custody are regarded as being 'a vulnerable group' under the Safeguarding Vulnerable Groups (NI) Order 2007.

1.3 As our focus was on suicide and self-harm prevention, this inspection examined the treatment provided to prisoners who were considered by the Safer Custody committees in each NIPS establishment between January to June 2009. This ensured that all prisoners who were identified as potentially vulnerable were considered. Inspectors also sought to establish whether some prisoners who should have been considered by safer custody committees were overlooked. Inspectors also examined correspondence with the Coroners Office into deaths in custody though there were no specific recommendations in relation to vulnerable prisoners.

1.4 The social and psychological profile of prisoners in Northern Ireland is different from the general population. Research shows that they have a higher experience of substance abuse (alcohol and drugs) and

psychiatric services. In addition they often come to prison with unsettled and chaotic lifestyles all of which contribute to their behaviour in a prison environment. They also have higher incidences of self harm and lower levels of educational attainment. In addition, it is estimated that 78% of male prisoners on remand and 64% of sentenced prisoners are personality disordered. Anti-social disorder (ASD) is the most common in all categories particularly among men. Many of these behavioural traits are exacerbated within prison making them difficult to manage. This is not to make the argument that people with personality disorder should not have been tried and sentenced for their offences – we would not suggest that this should be the case. It does, however, point to the fact that prisons are dealing with some very disturbed and dangerous individuals who are often a danger to themselves and others. While prisons are of themselves not therapeutic environments, there is a duty of care to provide safe, humane conditions and a therapeutic approach to prisoners – particularly vulnerable prisoners – in their care. When this care is not provided, as happened in the case of Colin Bell, the results can be tragic.

Previous inspection findings in relation to suicide and self-harm at NIPS establishments

Maghaberry Prison

1.5 Maghaberry is a high security facility and Northern Ireland's main adult male prison. It receives all newly committed prisoners, with an average of 20 per weekday and therefore has a high turnover rate. Maghaberry Prison is overcrowded with an average population of 820 remanded and sentenced prisoners. Prisoners range from short-term fine defaulters to life sentenced prisoners. The prison also holds around 70 separated loyalist and republican prisoners. It has an in-patient facility which cares for prisoners with mental health problems. Around 80% of the population of Maghaberry Prison are on prescription medication, reflecting high levels of need and vulnerability. Maghaberry established the Reaching out through Engagement, Assessment, Collaborative working and Holistic approach (REACH) landing in April 2007, to support those individuals identified as having a poorer capacity to cope with prison life or those with challenging behaviours.

1.6 Maghaberry was last inspected by CJI and HMIP in January 2009[1]. At that time Inspectors found a loss of direction was evident in a number of areas including poor attendance at meetings, a lack of strategic direction and no review of policy. Eight recommendations in relation to suicide and self-harm and violence reduction were found to be outstanding from a previous inspection[2]. These recommendations were therefore repeated and a further 12 recommendations were made.

1 CJI/HMIP An unannounced full follow-up inspection of Maghaberry Prison published July 2009- http://www.cjini.org/TheInspections/Inspection-Reports.aspx

2 CJI/HMIP A report of an announced inspection of Maghaberry Prison published May 2006 http://www.cjini.org/TheInspections/Inspection-Reports/2004-(2).aspx

Hydebank Wood Young Offenders Centre

1.7 Hydebank Wood YOC (YOC) holds approximately 200 young men aged between 17 - 24 in low security conditions. The population of the YOC is made up of individuals on remand and sentenced prisoners. Levels of volatility and vulnerability are often high among this age group.

1.8 The YOC was last inspected in November 2007[3]. At that stage, Inspectors found "*There had been no self-inflicted deaths in recent years and there were relatively few incidents of self-harm…there was an over-reliance on isolation and the use of suicide prevention clothing…rather than a therapeutic approach…The suicide prevention co-ordinator did not have enough time…procedures were often poor…*". Inspectors made four recommendations for improvement.

Ash House Women's Prison

1.9 Ash House is Northern Ireland's only women's prison. The average population is around 50 women, many of whom have serious social and emotional problems which can be compounded by the location of the women's prison within the same site as the YOC. The small population can have both positive and negative impact. On the one hand it can intensify difficult relationships while on the other, it can facilitate better levels of supervision and interaction between staff and prisoners.

1.10 The last joint inspection of Ash House by CJI and HMIP took place in October 2007[4]. It found that "*A full and separate self-harm and suicide prevention policy for women, taking into account their distinct needs, needed to be developed. There had been some improvements to support women at risk of self-harm, with less reliance on the use of strip clothing, but observation rooms were still used frequently, rather than a more therapeutic approach. The number of recorded self-harm incidents had fallen, but not enough was done to investigate serious incidents of self-harm. Support plans were poor. Training in suicide awareness and peer support for those at risk was insufficient.*"

Magilligan Prison

1.11 Magilligan Prison holds 400 sentenced male prisoners in medium security conditions. It has a relatively stable population as there are no remand prisoners and no in-patient facility. Consequently, only a small number of its prisoners are deemed vulnerable at any point in time.

1.12 Magilligan Prison was last inspected in May 2006[5]. At that stage Inspectors found "*there was little analysis of information …Prisoners at Risk (PAR 1) forms had not been opened in all appropriate cases...*" A total of nine recommendations for improvement were made including, the development of a vulnerable prisoner strategy and a more holistic approach to suicide prevention.

3 CJI/HMIP A report of an announced inspection of Hydebank Wood Young Offenders Centre published July 2008 – http://www.cjini.org/TheInspections/Inspection-Reports/2004-(4).aspx

4 CJI/HMIP A report of an announced inspection of Ash House, Hydebank Wood published June 2008 http://www.cjini.org/TheInspections/Inspection-Reports/2004-(4).aspx

5 CJI/HMIP A report of an unannounced follow-up inspection of Magilligan Prison published December 2006 – http://www.cjini.org/TheInspections/Action-Plan-Reviews – Inspection-Follow-Up-Revie.aspx

Vulnerable Prisoner Data

1.13 The NIPS provided figures which suggested the Northern Ireland rate of self-inflicted deaths in custody was similar to the rate in HM Prison Service in England and Wales and less than in the Scottish Prison Service:

- Northern Ireland Prison Service (NIPS) – 11.7 per 10,000 prison population;
- Her Majesty's Prison Service for England and Wales (HMPS) – 11.6 per 10,000 prison population; and
- Scottish Prison Service (SPS) – 15.8 per 10,000 prison population.

An average of eight prisoners per year died in custody of the Irish Prison Service between 2000 and 2008, but it was not known how many of these were self-inflicted deaths.

1.14 On 8 September 2009 there were 25 Prisoner at Risk (PAR) 1 files open on prisoners who were deemed vulnerable, out of a total population of 1,452 prisoners. This represents 1.7% of the prisoner population compared with 1.8% of prisoners who are vulnerable in England and Wales. Twenty-three of these were at Maghaberry Prison and two related to the YOC. There were none in either Ash House Women's Prison or Magilligan Prison.

Table 1 – NIPS PAR 1 database January to June 2009

	Hydebank Wood YOC	Ash House	Magilligan Prison	Maghaberry Prison	TOTAL
PAR 1s opened					
No. of prisoners	28 (incl 2 juveniles)	19	25	184	256
No. of occasions	33	40	36	248	357
Average duration - days	5	6	7	5	6
Range - days	1 – 27	1 – 40	1 - 60	1 – 1,026	N/A

1.15 The data in Table 1 clearly illustrates that the greatest concentration of vulnerable prisoners was at Maghaberry Prison. That is not to say that the other establishments did not have vulnerable prisoners on occasions, and their unique characteristics often meant that individual prisoners could display disproportionate needs. The short average durations of PAR 1s were encouraging in suggesting that once opened, prisoners were being actively managed and enabled to return quickly to a more stable lifestyle. However, repeat cases and the upper range levels indicate that there were some particularly entrenched and volatile cases to be managed.

1.16 The NIPS PRISM IT system provided the data in Table 1. PRISM had significantly advanced data capture opportunities, though this inspection found statistical inaccuracies due to recording difficulties, definition problems/overlaps and the timing of staff entries in relation to vulnerable prisoners. The NIPS was able to quickly remedy these deficiencies when they were identified by Inspectors. It is important that they maintain their efforts to ensure accurate data for management analysis and actively use the data that PRISM generates to manage their prisoner population.

CHAPTER 2:

Strategic context

2.1 While prisons are not therapeutic environments, some prisoners require a therapeutic approach during periods of vulnerability. The theory of how the NIPS aimed to look after vulnerable prisoners in its custody was articulated in a variety of formats:

NIPS 2009-2012 Corporate Plan and Business Plan

2.2 This document contained a section entitled '*Safer in Custody*' which suggested:

> *"A safer custody strategy is being produced for the NIPS, addressing age and gender-specific issues which are integral to delivering healthy prison. While physical measures such as the provision of safer cells will continue to be advanced, it is the culture of the prison, the extent to which people are treated with dignity and the quality of relationships between prisoners and staff, that will be the focus of [the] programme of work going forward."*

2.3 This was a positive statement insofar as it recognised the primacy of prisoner/staff relationships in helping to ensure a safe custodial regime.

NIPS policies and instructions

2.4 Inspectors saw a plethora of notices to staff - some 40 in total across the NIPS establishments. They covered a wide range of relevant topics such as:

- observation cell maintenance;
- supervisory responsibilities;
- reporting of self-harm incidents;
- recording Listener movements;
- entering PAR 1 details on the PRISM system;
- handover procedures;
- storage of emergency bedding supplies;
- smoking policy; and
- conducting communication checks.

2.5 These notices had been freshly issued, and in many cases were reiterations of existing policies. NIPS HQ had made it clear that copies of all policies in relation to safer custody were on the intranet and should be accessed by all staff. However some staff with whom Inspectors met were unaware of the updated suicide and self-harm policy, and did not even know where it could be found. This raises a serious concern about how well staff were actually imbued with the message. While the letter of recommendations was being delivered, the spirit was still missing in certain cases, and the challenge will be for

the NIPS to ensure an adequate level of staff awareness and application of safer custody procedures when another pressing priority arises.

2.6 It was clear from discussions that all staff had received an explicit message about the gravity of negligence that preceded the death of Colin Bell. Although there was some internal dissent – Maghaberry Prison staff were blamed for letting down the other prisons, and Night Custody Officers were blamed for letting down other groups of staff – everyone acknowledged the corporate reputational impact and need to improve delivery of services to vulnerable prisoners.

2.7 Inspectors found that updated policy guidance had been issued to NIPS staff, including arrangements for specific prisoner groups. This guidance included:

- 'Management of Juveniles in the YOC' (undated), though this was incidental in its references to safer custody;
- 'Draft Standards and consultation for working with Women Prisoners' (July 2009) were detailed in outlining how safer custody would be provided for the female population; and
- the revised 'Suicide and Self-harm Policy' (Sept 2006) and a January 2009 addendum which explicitly outlined requirements of staff.

Joint NIPS/SEHSCT REACH proposal (April 2009)

2.8 Responsibility for delivering prison healthcare transferred from the NIPS to the SEHSCT in April 2008. In the longer term the intention is that mental and other healthcare provided to prisoners will be similar to that for people in the community.

2.9 The NIPS headquarters had produced a detailed research paper that aimed to clarify the role of Maghaberry Prison's REACH landing, including its budget and interdisciplinary staffing arrangements. It outlined that each prisoner should have a nominated keyworker and person-centred plan, there should be a range of activities for prisoners along with specialist training and clinical supervision for staff. This proposal provided an ideal model, and in many ways was a reiteration of the original REACH concept from 2006. However by September 2009, there was little evidence that it was being delivered.

NIPS 'Development of a strategic approach to Safer Custody' (March and May 2009)

2.10 This strategy was developed by the senior Headquarters-based governor who had responsibility for safer custody. There was no record of the strategy being formally adopted by the NIPS. However it provided a solid vision, based on experience in other jurisdictions, an options appraisal and self-audits in each NIPS establishment. It went on to outline components of the safer custody strategy including:

- Prison Service Management Board (PSMB) endorsement and a PSMB champion;
- monthly safer custody reports to the PSMB;
- safer custody as a standing item on the PSMB agenda;

- an annual review of the safer custody strategy by a critical friend;
- the Supporting Prisoners At Risk (SPAR) process/document model; and
- an associated training matrix.

2.11 The safer custody strategy recognised the two fundamental elements. They were self-harm/suicide prevention and violence reduction/anti-bullying. It included proposals for dealing with both. It was apparent to Inspectors that the NIPS's emphasis in 2009 was on the former.

2.12 The violence reduction policy was embryonic and Inspectors saw evidence of piecemeal efforts across the NIPS estate. There was some good data available on PRISM about injuries and their causes for example assault, self harm, use of control and restraint. In addition, the safer custody managers were undertaking surveys and beginning to promote anti-violence messages within establishments. However, local safer custody personnel acknowledged that violence reduction had not received sufficient attention due to the emphasis on suicide and self-harm, and most staff felt a sense of inability to effectively address these issues. **We recommend that the NIPS should renew its efforts to promote violence reduction as part of its safer custody strategy in equal measure with the effort invested in suicide and self-harm.**

Prison Service Management Board (PSMB) minutes

2.13 The Prison Service Management Board (PSMB) took a significantly greater interest in safer custody from late 2008 onwards and this was reflected in Board minutes.

2.14 In January 2009, a Deputy Director noted improvements in PAR 1s and associated record keeping, but emphasised more needed to be done to evidence observations and checks. Safer custody and the Pearson Review Team recommendations featured as an agenda item, and it was noted that safer custody co-ordinators had been recently appointed to each establishment.

2.15 In February 2009 an update was provided on the McClelland Report and participants heard that "*The safer custody project is well underway…at HQ the safer custody branch is led by a senior governor who has responsibility for self-harm and suicide, violence reduction and the wider promotion of the culture of care…*"

2.16 Between March and June 2009 there was nothing noted in PSMB minutes about safer custody, despite the strategy recommendation that a champion should be appointed and safer custody reports provided monthly to the Board. However, safer custody again featured as an agenda item in the July and August 2009 PSMB minutes.

The Pearson Review

2.17 The Pearson Review was commissioned inter alia to take account of the development of performance management in the NIPS, quality assure the effectiveness of the NIPS Action Plans for implementing the Northern Ireland Prisoner

Ombudsman's recommendations, and to make recommendations that would assist the NIPS in developing a culture of care and accountability. The report was published in June 2009 and made a total of 38 recommendations.

The Ministerial Forum on Safer Custody

2.18 The Forum was set up to play a practical part in overseeing the implementation of the NIPS's Action Plans, and to ensure that the Prison Service's existing corporate safer custody project would be taken forward and fully implemented. The Forum aimed to add value in ensuring that vulnerable and challenging offenders were considered within the wider healthcare system as well as the criminal justice context. It also aimed to "*bring about a sustained reduction in the number of deaths and levels of self-harming in the Prison Service and Youth Justice Agency custody over the next three years and beyond.*"

2.19 It met quarterly, chaired by the Minister for Criminal Justice and comprised a large group of senior representatives from the criminal justice, healthcare and voluntary sectors.

2.20 These initiatives demonstrated that the NIPS clearly understood the issues involved in managing vulnerable prisoners, and was able to devise policies to suit. The challenge lay in giving effect to the spirit of their positive intentions at establishment level, and particularly in Maghaberry Prison.

CHAPTER 3:

Delivery and management of safer custody

3.1 Safer custody became a higher priority for the NIPS following public exposure of the negligence at Maghaberry Prison in relation to the death of Colin Bell. In addition to the Ministerial initiatives to establish the Forum on Safer Custody and the Pearson Review, the NIPS devised an Action Plan to implement the Northern Ireland Prisoner Ombudsman's recommendations.

The Action Plan

3.2 In response to the McClelland Report of January 2006 the NIPS had said that "*It is now established practice that Action Plans are prepared to assist the implementation of recommendations from reports.*"

3.3 Inspectors heard reports from various levels that the Action Plan was prepared by NIPS Headquarters officials without sufficient consultation, leading to unrealistic timescales and a lack of ownership at operational level. Inspectors were told there had been an inconsistent approach to debriefing staff after Colin Bell's death and after the publication of the Ombudsman's report.

3.4 Inspectors' assessment of the Action Plan and associated levels of achievement differs somewhat from the NIPS' own assessment. In our view some NIPS objectives do not fulfil SMART (specific, measurable, achievable, realistic and time-bound) criteria – a fundamental requirement of any good Action Plan. For example, those relating to Recommendations 24, 26, 32, 33, 39 of the Northern Ireland Prisoner Ombudsman's report.

3.5 We found there was room for improvement in how the NIPS handled inspection recommendations. The NIPS routinely accepted all recommendations, at least in principle, yet frequently failed to follow through. One example of this was the finding that 54% of the recommendations made in the joint inspection report of Maghaberry Prison published by CJI/HMIP in 2006 had not been implemented by the time the Inspectorates returned in 2009, despite the fact they had all been accepted.

3.6 As with previous NIPS Action Plans, the Colin Bell Action Plan confused *actions* with *outcomes*, and failed to recognise that many recommendations require continuous managerial attention and cannot be signed-off by a specific date. It was unclear who had the authority and capacity to

sanction the 'completed' status in this important document, and conclusions that some objectives had achieved 'completed' status were questionable. **We recommend the NIPS review and strengthen its capacity for more critical self-appraisal and recommendations should be followed by SMART Action Plans.**

Structural changes

3.7 A senior governor had been allocated the safer custody function at NIPS Headquarters in October 2006. However he was subsequently transferred to other duties for lengthy spells on two occasions. This governor returned to the safer custody role in November 2008 and made a positive impact. He was once more redeployed in June 2009, though it is perhaps fortuitous that he was posted to Maghaberry Prison where safer custody experience is most needed. Another appointee took up the safer custody lead role in August 2009, but CJI cautions against such frequent redeployments as they undermine the long term planning which is essential in an environment that will always be volatile.

3.8 One of the main structural improvements undertaken by the NIPS has been the establishment of safer custody teams in each establishment. This began at Magilligan Prison in December 2008 and at Ash House, Hydebank Wood YOC and Maghaberry Prison in February 2009.

3.9 The safer custody teams comprised a principal officer as manager in each establishment. In the case of Maghaberry Prison a second principal officer and a senior officer had been seconded temporarily for a limited period. Inspectors saw evidence of their positive impact in a variety of ways such as:

- they were auditing PAR1 documentation and providing feedback, on both positive and negative issues to staff;
- they had improved the frequency and focus of case conferences, ensuring that prisoners were attending and attempting to maximise inter-agency participation levels;
- they initiated surveys of night custody staff with a view to improving integration with other prison disciplines, and took follow-up action on the findings;
- they developed prisoner fora in Hydebank Wood YOC and Magilligan Prison; and
- they were beginning to address the anti-violence agenda for example by conducting a bullying survey in Hydebank Wood YOC.

3.10 In its 2007 inspection of the Northern Ireland Resettlement Strategy, CJI found *"Each custodial establishment has created resettlement posts which are supported by a Resettlement Team at NIPS HQ. All the people involved are clearly committed to the concept of resettlement. Unfortunately the model is frequently undermined by higher priorities, at both establishment and HQ levels. Redeployment of staff, excessive emphasis on security, and frequent prisoner transfers are the main problems. Progress on a range of NIPS human resources issues will be central to successful future delivery of the Resettlement Strategy."*

3.11 Up until 2009 exactly the same critique could be applied to the NIPS staffing allocation for safer custody. Inspectors were categorically informed by governors in each establishment that the safer custody posts will be ringfenced. However NIPS HQ took a different view and told us that "*…in the current economic climate the NIPS has made significant change which consequently requires managers to have and to operate with a complementary full job portfolio. It is unlikely that in the short to medium term future Governors will be able to give complete assurance that Safer Custody posts will be ring-fenced.*" Inspectors were told that other functions, such as equality and diversity have been added to the roles in some instances. If it is serious about safer custody, then the NIPS must maintain these teams and develop their roles.

Self-harm and suicide prevention fora

3.12 Inspectors were told that death in custody Action Plans and outcomes from Coroner's inquests were discussed at the bi-monthly service-wide Self-harm and Suicide Prevention Forum that involved representatives from all three Northern Ireland establishments. However, the minutes from four meetings in 2008 made no reference to progress on Action Plans. Some managers told Inspectors they saw Action Plans as a Headquarters function which resulted in little discussion, few learning opportunities and lack of operational ownership of plans.

3.13 Following the McClelland Report, the NIPS Action Plan said safer custody groups would be in place in each establishment by 31 January 2006; yet at Maghaberry Prison in January 2009, Inspectors found (and the NIPS accepted) that "*safer custody had largely been a neglected area for several years…*"

3.14 The Headquarters Suicide and Self-harm Prevention Forum was reinvigorated at the beginning of 2009, and met on three occasions between January and June 2009. Each establishment was represented and the meetings were chaired by the Headquarters-based safer custody co-ordinator. The Forum discussed a range of relevant strategic matters including:

- an audit of suicide and self-harm;
- timeliness of case conferences;
- deployment of suicide prevention co-ordinators in each prison;
- default 15 minute observations;
- strategies required to relocate prisoners from observation cells; and
- ways to improve PAR 1 recording.

Corporate data was reviewed, the vulnerability of foreign national prisoners was recognised, plans for availability and suitability of anti-ligature equipment, and Applied Suicide Intervention Skills Training (ASIST) were also on the agenda.

3.15 Within each establishment safer custody meetings, both strategic and operational, had begun in 2009. Detailed minutes were taken of these meetings and they represented positive progress from previous inspections. On occasions there was confusion between strategic and operational agendas, and full or partial PAR 1 reviews were

undertaken at strategic meetings, which was inappropriate. The most effective safer custody forum was at Magilligan Prison, where levels of inter-agency participation were high, NIPS psychologists played an active role, and meetings could be convened at short notice while achieving reasonable levels of participation.

3.16 It was early days as these strategic meetings had only been reinvigorated since January 2009. However by late summer 2009 some minutes suggested a dwindling attendance – an issue the NIPS will need to monitor carefully. It was also clear to Inspectors that multi-disciplinary participation levels were not always realised, which prevented full and informed discussion and decision-making. Partner agencies complained that some reviews were held at weekends when they were not in the prison; but this was essential for the NIPS to conduct safer custody business in an individualised and timely manner.

3.17 We also observed some meetings which were of poor quality because material evidence which should have been available was not known to participants. In one situation a prisoner had to provide criminogenic information about their current charges and previous custodial history. Such information should have been available to NIPS personnel, but those present were either covering for someone else or simply did not know. This was unsatisfactory and led to an inconclusive outcome. **We recommend the NIPS should by January 2010 revise its safer custody meeting structure to clarify participation and input expectations, differentiate between strategic and operational agendas and train staff in focusing on *outcomes* rather than *actions*.**

3.18 Inspectors noted instances where NIPS personnel were uncertain about their authority levels, not taking sufficient responsibility, and looked to others to deliver aspects of care plans for vulnerable prisoners. Again Inspectors were left with the strong view that a personal officer scheme – long resisted by the NIPS – would have worked very well for vulnerable prisoners. A personal officer scheme would entail a named officer taking responsibility for ensuring all elements of care plans were delivered for an individual prisoner. Inspectors understand the Supporting Prisoners At Risk (SPAR) process and a proposed new Case Manager system may address this issue, but consider the matter of such importance that in the meantime, **we reiterate our previous recommendations that the NIPS should introduce a personal officer/wing-based case manager scheme, at least on a pilot basis for prisoners who are considered by the safer custody committees.**

Practical initiatives

3.19 In addition to issuing orders and instructions, the NIPS had taken practical steps to improve prisoner safety, including the construction of additional observation cells, auditing for ligature points and remedying deficiencies. New anti-ligature knives and pouches were issued to optimise

responses in the event of discovering a prisoner hanging and a regime of regular tests of cell alarms and upgrades was introduced. Ash House, the YOC and Magilligan Prison conducted 'dry run' tests to establish staff response times in the event of an emergency unlock being required. A simple but effective step was taken by introducing magnetic door signs to identify PAR 1 prisoners and new committals so that night staff could pay them special attention.

Staff selection, deployment and training

3.20 Inspectors found that training levels to enhance the treatment of vulnerable prisoners had improved and some senior managers had received mental health training. The NIPS prioritised specialist training, with large numbers of staff receiving the Applied Suicide Intervention Skills Training (ASIST). There was also training in usage of new anti-ligature tools, and the safer custody staff received relevant training for their roles.

3.21 Job descriptions had been issued to explicitly clarify the supervisory requirements of managers. Oversight of night staff was now in place via pegging routines and radio checks, while senior officers visited vulnerable prisoners and conducted independent checks on their wellbeing three times per night. Bedding was stored centrally, closed circuit televisions (CCTVs) were monitored from Central Control Rooms and Night Custody Senior Officers (NCSOs) checked and initialled logs and records. A policy on managers viewing CCTV footage as a means of checking staff conduct awaited the outcome of negotiations with the POA.

3.22 Managerial access to permit unannounced night checks had been reviewed though remained problematic because of high security levels, especially at Maghaberry Prison. It was impossible for prison managers to reach any residential location without prior warning, because of the distance from the front gates and delays in access due to physical security features. Electronic access and pass key systems were being explored to alleviate the problem, and Inspectors saw evidence that governors were conducting night and weekend visits.

3.23 Despite physical limitations, a new climate was being introduced that placed greater emphasis on managers accepting responsibility commensurate with their role. The new Maghaberry Prison Governor had only been in post for one month at the time of this inspection, but he already had a plan to fulfil his various responsibilities, including the suicide and self-harm policy. Inter alia he directed in August 2009 that all residential managers should be based in prisoner accommodation houses to provide direct management support and accountability to staff, and he had established a change team to ensure outstanding inspection recommendations were delivered.

3.24 Handovers were taking place at the end of each shift and were being recorded. However, in some cases they were cursory, and even on the

REACH landing did not convey any sense of the group dynamics among prisoners and staff. There was no impression that individual prisoner's circumstances merited attention, save in extreme circumstances.

3.25 By September 2009 there had still been no corporate or local exercises to determine whether Night Custody Officers (NCOs) or other staff were double-jobbing. Inspectors were told this important concern was overlooked because NIPS Headquarters thought local governors were undertaking the task, yet governors thought it was being carried out by Headquarters staff. This is another example of inadequate action planning and poor communication, especially as the NIPS Action Plan suggested these recommendations (numbers 19 and 20 in the Northern Ireland Prisoner Ombudsman's report) were completed by 31 August 2009.

3.26 Subsequent to the inspection, the NIPS told CJI that an instruction had been issued requiring personnel governors to ascertain the identity of any NCOs who had second jobs. All staff were instructed that such jobs should not interfere with their primary role within NIPS, and specifically that they should not undertake any tasks prior to commencement of any night duty within NIPS. Personnel governors had then issued an instruction to staff reminding them of their primary obligation to the NIPS and requesting information about any other work activities outside of NIPS. The NIPS aims to complete this process by the end of December 2009. CJI will seek evidence of progress in this matter in early 2010.

The REACH landing

3.27 The REACH landing in Maghaberry Prison's Lagan House was intended as a specialist location for vulnerable prisoners. The original 2006 concept entailed a multi-disciplinary staff group for approximately 20 prisoners who would be provided with a therapeutic regime. Staff received special mental health training and 12 spent a week at Whitemoor maximum security prison in Cambridgeshire in preparation for working on the REACH landing. The physical environment on REACH was highly unsuitable – it comprised a regular Maghaberry Prison residential landing that was drab and narrow, devoid of any therapeutic tone or facilities.

3.28 REACH never achieved its potential. Despite a theoretically higher staffing quota, its staff were regularly redeployed due to shortages of personnel at other locations in Maghaberry Prison. The allocation of resources within the Prison is at the discretion of the Governor and local management teams. Decisions on the ground in relation to those jobs that may be dropped or postponed are taken with reference to an agreement between the NIPS and the Prison Officers Association (POA). **We recommend the Maghaberry Governor should undertake a review of the current arrangements for staff allocation in consultation with the POA in order to deliver a more flexible approach to resource allocation**

that will help deliver an improved regime for vulnerable prisoners.

3.29 Inspectors met excellent staff on the REACH landing, but others had become disillusioned, and some levels of cynicism were inappropriate for the environment. Most of the original complement of trained staff had dwindled by the time this inspection was carried out, and was supplemented by officers with no particular background or interest in working with vulnerable prisoners. Prison officers found it challenging to deliver different regimes to the various categories of prisoner on the REACH landing. They included fine defaulters, returned lifers, remand prisoners, foreign nationals and sex offenders, many of whom were not vulnerable.

3.30 Some prison officers told Inspectors they were unclear about who actually controlled access to and from REACH - the safer custody Principal Officer or the Lagan House Principal Officer. Simple structural uncertainties such as this cause confusion and limit the opportunity for prisoners to be properly managed. They should be clarified immediately, especially when the need is significant.

3.31 Another fundamental difficulty for REACH was that its prisoner population did not adhere to the original intention. REACH prisoners were meant to be selected according to their levels of vulnerability and need, and return to a normal location when their problems became more manageable. However, because of overcrowding throughout the prison all types of prisoner ended up on REACH and levels of vulnerability were often irrelevant as bedspace pressures prevailed. **We recommend the NIPS should prioritise implementation of the REACH proposal that was devised with the South Eastern Health and Social Care Trust (SEHSCT) in April 2009.**

3.32 Inspectors were told of plans to transfer up to 100 prisoners from Maghaberry Prison to refurbished accommodation at Magilligan Prison. If and when that takes place, it will undoubtedly assist better functioning of REACH as well as the rest of Maghaberry.

Self-audit

3.33 The NIPS had set about a vigorous self-audit process as part of its efforts to redress the malpractice surrounding Colin Bell's death. At Hydebank Wood YOC and Magilligan Prison, Inspectors saw written audit reports following tests of special accommodation and clothing, staff reaction times and access to anti-ligature equipment. These concluded with helpful options, appraisals and recommendations.

3.34 Thorough audits had been undertaken of observation cells for ligature points and problems eradicated where they were identified. Where relevant, learning had been shared across the NIPS and with other agencies such as the Police Service of Northern Ireland (PSNI) and Youth Justice Agency (YJA).

3.35 An internal safer custody audit at

Maghaberry Prison was commissioned in June 2009 and an external audit in August 2009. Both audits highlighted several ongoing concerns a year after the death of Colin Bell. The external audit was especially critical and made 65 recommendations for improvement. Many of its comments reflect the findings of this inspection:

- On PAR 1's – "*Case reviews were frequently not multi-disciplinary…the care plans put in place were not so much care plans, more a list of things to do…they had no named person to take responsibility of action.*" (p.3)
- On Healthcare – "*…it was noticed that healthcare do not routinely attend reviews or contribute a written submission. Staff on Lagan [House] said they had done emergency referrals for prisoners on PAR 1's to mental health and they had been told it would be at least two weeks*". (p.4)
- On REACH – "*… staff who work on REACH are being re-deployed to other landings in Lagan House, meaning the REACH prisoners are being kept locked up for large parts of the day. For the type of prisoner REACH caters for this is not appropriate.*" (p.5)

3.36 The external audit conclusion was to award Maghaberry Prison a 'Red' risk rating "*…due to the lack of policies, procedures, general management and seriously high risk of further Death in Custody and/or Homicide…*" (p.9).

3.37 The NIPS told CJI that this report was specifically requested by the new Governor at Maghaberry Prison for internal use to inform operational decisions in relation to safer custody; and that the Safer Custody project plans at Maghaberry Prison and at Headquarters will take account of many of the comments that were made in that report. Inspectors will wish to assess progress against its findings in Spring 2010.

The McClelland Report

3.38 The McClelland Report produced 30 recommendations in January 2006, all of which were accepted by the NIPS. Minutes of the February 2009 Prison Service Management Board (PSMB) meeting suggest "*An Action Plan was developed and an updated copy presented to Board members. The Safer Custody Support Manager advised that of the 30 recommendations, 14 have been actioned, four partially actioned and five working towards completion with work continuing in these areas as a matter of priority. Some of the issues in the Action Plan relating to mental health issues are being taken forward in discussions with the SEHSCT who are pro-active in the care of mental health needs in prisons.*"

3.39 By September 2009, many of the McClelland Report recommendations had undoubtedly been addressed. For example staff training, revamping the PAR 1 process, sharing information between disciplines and establishing Listener schemes had all been achieved. Gains had been made in areas such as a new reception and drug testing facility for the women at Ash House, introducing pet therapy, creating a family support group, introducing cottage industries and the new standards framework. However, Inspectors' assessment is that there is still considerable scope for progress in respect of McClelland's recommendations to "*improve levels of activity for vulnerable prisoners*," "*reduce*

the level of control in establishments" and that "*Ash House should operate with a clear therapeutic ethos.*"

Chronic Pathologies Review

3.40 As part of its effort to address the demands of vulnerable prisoners at Maghaberry Prison, the NIPS undertook a 'chronic pathologies review' in February 2009. This aimed to identify the most urgent cases for review – 18 in total – and whether their risks were static, escalating or de-escalating. After all active PAR 1 cases were reviewed, the Safer Custody co-ordinator and healthcare personnel also considered challenging cases which were not currently subject to a PAR 1.

CHAPTER 4:

Outcomes for prisoners

Assessment and opening PAR 1s

4.1 Prisoners usually came to the attention of the safer custody committee following actual or threatened incidents of self-harm. A recent initiative also provided for safer custody consideration when PRISM triggered concerns. For example, if a prisoner was on basic regime for four weeks or had a prolonged lack of visits. This was a welcome level of proactivity that resulted from the initiative of the safer custody personnel.

4.2 Inspectors did not find any cases of self harm or other forms of injury which should have been considered by safer custody groups but had been overlooked. This represented progress since previous inspections and the NIPS expected the situation would improve further with refreshing of the PRISM IT system in December 2009 as the refreshed system is intended to record all incidents of self harm and provide alerts to safer custody teams.

4.3 Many PAR 1 files that were considered appeared to be as a result of caution on the part of the NIPS, and they were able to be quickly closed. A more concerning factor however was staff reluctance to open or maintain a PAR 1 when they believed prisoners were attempting to manipulate the system in order to acquire advantage, for example, prisoners on basic regime who wanted to have a television.

Observation cells and anti-ligature clothing

4.4 At the time of this inspection there was a tendency among NIPS personnel to place prisoners in observation cells and in anti-ligature clothing, with 15 minute observations by default, once a PAR 1 file was opened. The norm was an initial 24-hour placement, and it was apparent from files and interviews that this was not always individually risk assessed. An observation cell was clearly required when there was an immediate risk of self-harm, but a 24-hour minimum stay should not be the default response as a prisoner's own cell in a normal location, is likely to be more conducive to stability than placement in an observation cell.

4.5 Although some personal possessions could be retained in observation cells, prisoners' shoes were routinely withdrawn. This appeared unnecessary as long as ligatures such as laces were removed, along with sharp objects and

Table 2 – NIPS PAR 1 database January to June 2009 by Regime level, Observation cell, Segregation Unit (SSU) and anti-ligature clothing usage

	Hydebank Wood YOC	Ash House	Magilligan Prison	Maghaberry Prison	TOTAL
Regime level					
Enhanced	7	4	5	31	47
Standard	21	33	16	166	236
Basic	5	3	15	51	74
Observation cell used					
No. of prisoners	10	10	7	71	98
No. of occasions	10	25	12	184	231
SSU used					
No. of prisoners	3	NA	16	12	31
No. of occasions	3	NA	51	12	66
Anti-ligature clothing used					
No. of prisoners	4	3	2	60	69
No. of occasions	4	7	2	156	169

Table 2 demonstrates that regime levels were not particularly significant in determining whether a prisoner was likely to be at risk.

medication. Consequently we re-emphasise the need for individualised decisions about relocating prisoners once they are deemed vulnerable, rather than by default to 24-hour placement in an observation cell.

4.6 Inspectors heard a unanimous view from Maghaberry prisoners who had been accommodated in the observation cells that they were cold at night. This was confirmed by Listeners who had visited the cells at night, and by Inspectors' own assessment. Although temperature checks had been conducted in Maghaberry Prison's observation cells, these were done during daylight hours in July and August which would not produce representative readings. Subsequent to the inspection, the NIPS informed CJI that instructions were issued to governors that prisoners located in observation cells should be given a quilt unless there was a significant risk which highlighted additional safety concerns. Prisoners in observation cells in Maghaberry Prison now also had access to slippers. In addition, work was being progressed to install flush panel heaters in the ceiling of observation cells at Maghaberry Prison, with work due to be completed by the end of

December 2009. This is a very important matter which CJI will return to examine in early 2010.

4.7 The observation cells were stark, and several prisoners whom we met were keen to have their PAR 1 status closed because they felt it stigmatised them. Many said that their experience of being placed in an observation cell, in anti-ligature clothing, felt like a punishment rather than being in a place of safety. They resented being regularly awoken throughout the night and were bored in their bare surrounds. Night Custody Officers (NCOs) tried to be sensitive in conducting their 15 minute observations, but their paramount concern was to confirm that PAR 1 prisoners remained alive.

4.8 Prison officers had become more alert to good practice around the usage of observation cells, authority levels for their extended use and anti-ligature clothing. However, some officers at Maghaberry Prison proffered the view that observation cells were occasionally used inappropriately for punishment. This was confirmed by Inspectors' own observations. Following a fight between prisoners on another landing which led to the complete lockdown of Lagan House for over 24-hours, a PAR 1 prisoner whom we met, had spent the night in an observation cell. He had protested at the collective punishment by shouting and banging on his cell door, and was moved to an observation cell overnight. Neither the prisoner or staff members on duty were clear why he was moved to this location, but he certainly felt it was punitive.

4.9 NCOs were required to attempt conversational checks in their engagement with prisoners primarily as a method of ensuring vulnerable prisoners were safe and also to engage them in social interaction. This was difficult at night when conversations had to be held through a cell door and confidentiality could not be maintained.

Placements in Special Supervision Units (SSUs)

4.10 The main purpose of Special Supervision Units (SSUs) was to isolate refractory prisoners, but they were also used to hold vulnerable prisoners - a practice that has always been deemed inappropriate by Inspectors. Whilst there is no prior benchmark for the data in Table 2, Inspectors were told the trend was reducing. Magilligan Prison had completely ceased placing vulnerable prisoners in its SSU once new accommodation opened there in March 2009. Ash House did not have an SSU, and the numbers in Hydebank Wood YOC were very low. It was anticipated that SSU placements for vulnerable prisoners at Maghaberry Prison would reduce significantly once its new observation cells became available by Christmas 2009.

Emergency access

4.11 Emergency cell access equipment for NCOs was provided at Ash House, Hydebank Wood YOC and Magilligan Prison but not at Maghaberry Prison. This was because the NIPS had been unable to find a way of enabling night staff to carry keys that they felt did not compromise the establishment's

security. Consequently, vital time could be lost in the event of having to conduct an emergency unlock at Maghaberry Prison. Subsequent to the inspection, the NIPS informed CJI that work is progressing to introduce a new procedure which will permit NCOs to carry cell keys at night. Special pouches are being provided. New instructions will be introduced when the pouches become available which will allow NCOs to access cells without incurring a delay by having to obtain the key from the secure pod. The NIPS anticipated that this work will be completed early in the New Year. CJI will return to examine progress in this area in early 2010.

Regimes

4.12 Previous inspections of NIPS establishments have routinely criticised the regimes provided to prisoners as inadequate. They have stated that they are unduly influenced by security considerations, even at Magilligan Prison, which purported to be a training prison, and for the young male population at the YOC. Access to work, education and other positive interventions were insufficient and too much time was spent in cell.

4.13 Impoverished regimes remained a concern at the time of this inspection. The situation was exacerbated by industrial action by the POA during January to July 2009, characterised as a 'withdrawal of goodwill' which led to further regime slippage in all establishments, including for vulnerable prisoners. The practical impact was that prisoners were locked in their cells for even longer periods than normal, exactly the opposite of what was required for vulnerable prisoners, who should be encouraged to have as much social interaction as possible.

4.14 PRISM data strikingly illuminated this scenario. Actual attendance at the prison gardens (one of the main therapeutic features supposedly on offer to REACH prisoners) was only 17% of predicted attendance between January to June 2009.

4.15 One week of activity data for 16 REACH prisoners in August 2009 (after POA action was concluded and normal regimes should have been re-established) showed actual attendance was 45% of predicted attendance. This was all the more concerning as the prisoners had very little activity scheduled in the first place, and the definition of 'activity' incorporated matters such as legal interviews, court attendance, police interviews and medical appointments. **We recommend the NIPS should redefine its activity categories to more accurately distinguish constructive activities from routine aspects of prison life.**

4.16 The REACH regime was acknowledged by everyone as poor. Complaints of boredom were frequent, and none of its prisoners were visibly engaged in a programme of constructive activities during the course of this inspection. PAR 1 prisoners told us they had expected that placement on REACH would entail sessions with therapists, regular gym and work in the REACH garden or elsewhere, but few of these materialised.

4.17 The *Stepping Stones* programme was an imaginative attempt to assist long-term basic regime prisoner's return to the standard regime level by providing individualised incentives. Although there was no data about the success of this programme, Inspectors saw examples of staff compassion, as well as judicious exercise of discretion in not charging prisoners when their behaviour was unacceptable. Prisoners were often cynical about the lack of follow-up activity by staff, but most were able to identify officers to whom they could turn at times of difficulty.

4.18 The negative impact of local arrangements overriding the corporate approach was apparent at the YOC and Ash House. PAR 1 prisoners there were not permitted to work because vocational skills training instructors were fearful of managing the risks, and this had been the accepted practice for several years. This was clearly a counter-therapeutic situation, which was promptly remedied by the Governor when identified by Inspectors.

4.19 Magilligan Prison, the YOC and Ash House had undertaken surveys of prisoners and established fora as a means of seeking views and feedback. Inspectors observed some of these meetings and read minutes of others. These initiatives, which were led by the safer custody teams, were positive steps towards prisoner consultation and benefitted vulnerable prisoners as well as the rest of the population. Despite longstanding resistance within the NIPS to such consultation, the fora were raising worthwhile issues. Prisoners treated them seriously and valued the opportunity to engage with managers. They used the opportunities to ventilate maturely, accepted responsibility for representing others' views, and demonstrated they could engage in a sensible debate about prison life. **We recommend that Maghaberry Prison should establish a prisoner forum.**

The Listener Scheme

4.20 The Listener scheme entailed prisoners providing emotional support to other prisoners upon request. The scheme was well designed, and enjoyed good support from the Samaritans and from sponsoring prison officers. Recruitment and training arrangements were good and the Listeners whom Inspectors met were reflective and discerning in their approach to the role. They could quickly distinguish between genuine need and someone who did not require Listener intervention. While some prisoners were sceptical about having a Listener, they were generally well-received and valued by those who used the service.

4.21 The scheme operated best at Maghaberry and Magilligan Prisons. It had proven difficult to implement at Ash House as the female prisoner population was too small to generate a pool of eligible and willing candidates and in the YOC because most of the young male prisoners were either not mature enough or in custody for an insufficient length of time.

4.22 Overall the Listener schemes were underdeveloped: whereas the Samaritans recommended a ratio of

1 Listener/50 prisoners, Maghaberry had only 3 Listeners/800 prisoners at the time of this inspection. Many applicants were rejected on security grounds, and on occasions the scheme was impeded by officers making access difficult within the confines of the prison. Maghaberry Prison regularly lost trained Listeners on transfer to Magilligan Prison to ease bedspace pressures in Maghaberry. **We recommend the NIPS should set targets for increasing the numbers of Listeners in each establishment and produce an Action Plan to improve their deployment.**

Documentation

4.23 Inspectors viewed PAR 1 files in each establishment as part of this announced inspection. The documentation had improved from previous inspections insofar as greater detail was entered on PAR 1 files. Yet much case recording was done by rote and afforded no real insight into prisoners' circumstances. Most PAR 1 file entries were voluminous but highly repetitive and of little value in analysing the prisoner's progress. Observational night checks were often predictable and not individualised to the circumstances of the particular prisoner. We noted that staff frequently did not do justice to some good work by failing to record conversational checks. In addition to these important qualitative concerns, the NIPS Director of Operations and safer custody principal officers had recently provided feedback about gaps in recording, suggesting that some staff were unable to meet even the most basic recording expectations.

4.24 The internal audit of safer custody at Maghaberry Prison further suggested that staff were used to making retrospective file entries. Such recording practice is inappropriate at best, potentially improper and should not be tolerated.

4.25 Inspectors read caustic feedback to line management in a PAR 1 file; and we found a glaring gap in recording interventions with an Ash House prisoner at a time of high vulnerability. When Inspectors queried this, an immediate response was provided which suggested appropriate steps actually had been taken, yet the file contained absolutely no such evidence. **We recommend the NIPS should provide guidance on basic file recording for its staff who interact with prisoners; and follow this up with an audit to measure improvements.**

4.26 Much work had been undertaken in developing the Supporting Prisoners At Risk (SPAR) process as a replacement for PAR 1. SPAR was piloted at Ash House and the YOC, and although there were some delays, it was planned to be fully implemented by December 2009. Evaluations were conducted by the NIPS after the YOC and Ash House pilots. They suggested several benefits, including good completion of booklets, the system was clearer and easier to apply than PAR and there was less usage of observation cells and anti-ligature clothing.

4.27 Inspectors' initial assessment is that SPAR is superior to PAR, both in its documentary content and especially in the fact that SPAR requires a case

co-ordinator, specifically trained for the role. If properly implemented this should go some way towards resolving the deficiencies caused by the lack of a personal officer scheme. We will take account of SPAR's progress when revisiting the safer custody theme in early 2010.

Section 2

Appendices

Appendix 1
NIPS achievement of recommendations made by the Prisoner Ombudsman in the Colin Bell case

At 8 September 2009, CJI Inspectors found that:

- 21 recommendations were achieved;
- 16 were partially achieved/ongoing; and
- 6 were not achieved,

Our main conclusion was that while there had been good progress in some key areas, least progress had been made in the care of vulnerable prisoners and the regime provided for them. This was a fundamental concern. Most progress has been made in relation to 'policy initiatives (66% achieved) compared with 39% of 'operational' issues.

Recommendations relating to Safer/Observation cells

1.	Ensure all staff are aware of Observation cells and Suicide and Self-Harm (SSH) policies	Partially achieved
2.	Authorise extension beyond 24 hours	Achieved
3.	Ensure all staff carry out 15 minute observations	Achieved
4.	Introduce recorded conversational checks	Achieved
5.	Checks should be unpredictable	Partially achieved
6.	PAR 1 & Confinement Restraint Clothing (CRC1) checks should be recorded	Achieved
7.	Checks should be individualised	Partially achieved
8.	Construct extra safer cells	Partially achieved
9.	Audit observation cells for ligature points	Achieved

Recommendations relating to ligature points in safer cells and Secure PODs

10.	Remind staff to keep PODs secure	Achieved
11.	Remind staff makeshift beds are forbidden	Achieved
12.	CCTV is regularly observed	Achieved
13.	Remove TVs from PODs	Partially achieved
14.	Make staff aware of need to check and record that CCTV is operational	Achieved
15.	Remind staff to check safe cell CCTV every 15 minutes	Achieved

Recommendations relating to anti-ligature clothing

16.	Revise authorisation policy for extending use of anti-ligature clothing	Achieved
17.	Ensure prisoners in anti-ligature clothing are kept warm and offered suitable footwear	Not achieved

Recommendations relating to Night Custody Officers and Handover arrangements

18.	Introduce night breaks for NCOs	Partially achieved
19.	Ensure awareness of NCOs double jobbing	Not achieved
20.	Update records of staff other jobs	Not achieved
21.	Governors involved in recruitment/shift arrangements	Partially achieved
22.	NCOs should receive vulnerable prisoners training	Partially achieved
23.	Senior staff should receive mental health training	Partially achieved
24.	Review adequacy of briefing/training for REACH staff	Achieved
25.	Appropriate and recorded handovers take place	Achieved

Recommendations relating to night shift supervision

26.	Review adequacy of management access for night checks	Partially achieved
27.	Provide job descriptions for Night Custody Prison Officers (NCPOs) and Senior Officers (SOs)	Achieved
28.	Increase night supervisory visits and vary times	Achieved
29.	Advise NCSOs to physically check PAR 1s, records & CCTV	Achieved
30.	NCSOs check records and discuss CCTV monitoring	Achieved
31.	Review training of NCSOs to ensure competence in all their responsibilities	Partially achieved

Recommendations relating to the care of vulnerable prisoners

32.	Improve PAR 1 regimes	Not achieved
33.	Each prisoner with a multi-disciplinary care plan should have an assigned care co-ordinator	Not achieved
34.	Audit REACH staffing training, handover, supervision to identify positive adjustments	Achieved

Recommendations relating to Samaritans Listener Scheme and risk assessment of threats

35.	Ensure staff are aware of and apply Governors Orders re the Listener Scheme	Achieved
36.	Record all requests for Listeners	Partially achieved
37	Review policy for involving the PSNI in threat risk assessments	Achieved

Recommendations relating to Smoking policy and Hot/Cold Debriefs

38.	Remind staff of the NIPS Smoking Policy	Achieved
39.	Include Emergency Control Room (ERC) rep at all hot and cold debriefs	Partially achieved
40.	Conduct cold debriefs within 14 days	Partially achieved

Recommendations relating to accessing cells and corporate responsibility

41.	Provide emergency cell access equipment for Night Custody Officers (NCOs)	Not achieved
42.	Introduce robust self-audit	Partially achieved
43.	Ensure the Maghaberry Prison governing Governor delivers all responsibilities in the Suicide and Self Harm (SSH) policy	Partially achieved

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