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national preventive mechanism

Overview of initial findings of a report on an announced inspection of

MAGHABERRY PRISON

4-15 January 2016

February 2016

HM Inspectorate of Prisons

The Regulation and Quality Improvement Authority

eti

Criminal Justice Inspection Northern Ireland
a better justice system for all

national preventive mechanism

Overview of initial findings of a report on an announced inspection of

MAGHABERRY PRISON

4-15 January 2016

by the Chief Inspector of Criminal Justice in Northern Ireland, Her Majesty's Chief Inspector of Prisons, the Regulation and Quality Improvement Authority and the Education and Training Inspectorate.

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.

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Criminal Justice Inspection Northern Ireland
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Contents

List of abbreviations

CJI	Criminal Justice Inspection Northern Ireland
ESOL	English for Speakers of Other Languages
ETI	Education and Training Inspectorate
HMIP	Her Majesty's Inspectorate of Prisons in England and Wales
MDT	Mandatory Drug Test
NIPS	Northern Ireland Prison Service
NPM	National Preventive Mechanism
OPCAT	Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
PDU	Prisoner Development Unit
PECCS	Prisoner Escort and Court Custody Service
PSST	Prisoner Safety and Support Team
RQIA	Regulation and Quality Improvement Authority
SEHSCT	South Eastern Health and Social Care Trust

Chief Inspectors' Foreword

Background to the inspection

Maghaberry Prison remains a complex and challenging establishment which in the context of the United Kingdom is unique. It holds approximately 1,000 men ranging from those on remand and serving short sentences, to lifers and separated paramilitary prisoners. It is the only prison in Northern Ireland that can hold Category A prisoners and for many serving longer sentences, they will spend most, if not all of their time at Maghaberry. Many of the prison population have learning difficulties, mental health issues, addiction problems and personality disorders and it was notable that in the seven months since our last inspection in May 2015 this extreme level of vulnerability had become more marked.

Historically we have found Maghaberry to be a prison which has struggled to adapt to the requirements of a 21st century establishment, and one where the legacy of the past has been a major impediment to its progress in providing safe, decent and rehabilitative outcomes for the men held there.

At our inspection in March 2012 we were somewhat more positive and this was reflected in our commentary where we said: *'We found encouraging signs of improvement in some key areas and while significant weaknesses remained, we were encouraged that the prison was making progress.'*

It was therefore with considerable disappointment and concern, that on our return to the prison unannounced in May 2015 we found what we described as a prison in crisis. We summarised this in the following terms:

'Overall, this was a concerning inspection of a prison which was as bad as any we have seen in

recent years. Inspectors met a number of good, motivated managers and staff who gave us some hope that with the right kind of leadership and tangible support, Maghaberry could recover and again reach a point where progress could be made. However, a significant failure in leadership was compounded by an ineffective relationship between [Northern Ireland] Prison Service (NIPS) headquarters and local management which needed to be urgently addressed. A general malaise was evident at Maghaberry, which sought to attribute blame rather than find solutions to problems. There also was an unhealthy combination of high sickness absence and poor staff morale which served to exacerbate these issues.'

Given the extent of the problems we found, we made a decision to reduce the number of recommendations in the subsequent report (published November 2015) to nine key areas of concern (see Appendix 3). In the meantime we provided prison managers and the NIPS with a summary of these key findings and concerns. We also made the unprecedented decision to return to the prison for a follow-up inspection in January 2016. This not only indicated the depth of our concerns about what we had found, but was also intended to communicate the urgency of much of what we felt needed to be done, and by making the inspection announced, provided a clear timeframe and focus for senior managers to start the process of transformation that in our view was needed.

Given the short timescale since the previous full inspection, we decided not to re-visit our healthy prison assessments from May 2015, but to instead concentrate on whether progress was being made, or was planned, to address our nine recommendations. This follow-up report provides a summary of our assessment as to the state of progress so far at Maghaberry. As we made clear to the authorities responsible for the prison however, we consider the recommendations we made in 2015 to still be extant requiring on-going follow-up review.

The current inspection

At our last inspection in May 2015 we rated outcomes in **safety** as poor overall. We considered the prison to be unstable, processes to manage poor behaviour were ineffective and we recommended that urgent action was needed to strengthen leadership. We called for an independent investigation of a serious fire at Erne House. We also considered care of vulnerable prisoners to be inadequate.

At this inspection we found that some progress had been made in addressing our concerns although prisoner experiences and perceptions still pointed to many problems. Urgent action had been taken to strengthen leadership, with a new governor and transformed senior management team who were now focused on stabilising the prison, rather than as previously, blaming others for the problems being experienced. A review of the Erne House fire had very recently been completed and lessons were being learned. A start had been made in tackling the challenges around safety, and there were credible plans to do more. Staff had begun to provide some supervision in association rooms and exercise yards, and there were plans to extend this and embed a more dynamic and modern approach to security. However, whilst recognising the progress being made, we cautioned that a significant amount of work was

still outstanding to make Maghaberry safer and for this to reflect more positively in prisoners' experiences. We cautioned that levels of violence remained too high, problems with illicit drugs and diversion of prescribed medications were pervasive, and many safer custody processes were either fragile or not functioning effectively. We were also concerned that allegations of staff assaults on prisoners were not being adequately investigated.

At the last inspection we rated outcomes in **respect** as poor overall. We considered that the demands of the separated units were undermining the work of the whole prison. We were not assured that there was equal treatment for all prisoners, particularly Catholic men and those with disabilities and health care services required urgent improvement to ensure patient safety.

At this inspection we found that attention had been given to reducing the impact of the separated prisoner units on the rest of the prison, but this remained challenging and complex. It was positive that the staff working in Roe House were now being better supported. Support for disabled prisoners had improved although more needed to be done to meet all the needs of the diverse population held. Little if any progress had been made in understanding and addressing poorer outcomes being experienced by Catholic prisoners and this remained a concern. Whilst some aspects of primary health care had improved it was very worrying that mental health provision had deteriorated as a result of staff shortages since the last inspection and now needed urgent attention. Given the prevalence of such health problems in the population this was a significant additional area of concern and we have been reassured that the South Eastern Health and Social Care Trust (SEHSCT) is prioritising this issue.

At the last inspection we rated outcomes in **purposeful activity** as poor. We assessed learning and skills provision as inadequate and in need of urgent improvement.

At this inspection we found reasonable progress had been made in improving the quality of learning and skills provision. Belfast Metropolitan College had taken over responsibility for most of the education at the prison since the last inspection and were working well with prison managers to develop the provision. More prisoners were attending activities and achievements were increasing. The new core day was a significant initiative to support this move and was starting to provide a better focus on delivering a more purposeful and stable regime. Nevertheless, too many men were still without any activity and curtailment of the regime remained significant, although it was reducing.

At the last inspection we rated outcomes in **resettlement** as reasonably good but recommended that provision should be based on a robust needs analysis of the population.

At this inspection we found that progress had been made in better understanding the needs of the population, although this had not yet been fully embedded in what was being delivered. Offender management arrangements remained reasonably strong despite some staffing issues and prisoners were generally well supported by specialist staff in addressing their risks to others. Through-the-gate support remained generally good benefitting from some excellent

partnership working. Nevertheless, we still did not see that mass of staff at Maghaberry playing an effective role in a more holistic approach to the resettlement of prisoners. We considered that house-based staff still had low expectations of the men in their care and were not using their influence or input to support work being done to turn prisoners from a life of crime to a more productive future.

This last point hints at one of the deep-seated issues affecting Maghaberry. Whilst the senior management team had started to raise expectations of what it wanted from and for the men in its care, and this was reflected in some of the staff we met, it was not the norm. Many staff continued to adhere to a view that prisoners were to be feared, and that they could do little to influence prisoners custodial, or future behaviour on release.

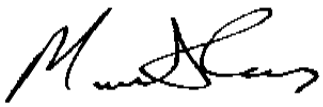
This is a matter of culture and one which will be difficult to change. It will take time, but it is in our view, essential for the long-term modernisation of the prison to make it fit for the 21st century.

In time we will publish a fuller report of our visit, and outline formal progress against the recommendations made in May 2015. As indicated we have already advised senior NIPS managers in Northern Ireland of our intention to work with them to review the nine substantive recommendations through a series of announced, low impact visits to the prison.

We commend the seriousness with which the NIPS has taken our recommendations made in May 2015, and the urgent action taken to date making a start in addressing our concerns, but this early momentum now needs to be maintained in order for the significant progress still needed, to be achieved.

Brendan McGuigan
Chief Inspector of Criminal Justice in Northern Ireland

February 2016



Martin Lomas
Deputy Chief Inspector of Prisons in England and Wales

February 2016

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Fact page

Task of the establishment
Maghaberry is Northern Ireland's only high security Category A prison. It houses adult male sentenced and remand prisoners. The prison serves the courts in the whole of Northern Ireland and helps prisoners prepare for their release into the community.

Prison status
Public.

Department
Department of Justice Northern Ireland.

Number held
At the time of inspection, 885.

Certified normal accommodation
1,014.

Operational capacity
A maximum of 1,456; however, the number of prisoners held in the square houses was limited, reducing this significantly.

Date of last full inspection
May 2015.

Brief history
The Maghaberry site originally included two prisons: the women's prison, Mourne House, was the first part of the new prison to be opened in March 1986; the men's prison became operational in 1987.

Following the closure of Belfast (Crumlin Road) prison in 1996, Maghaberry Prison became Northern Ireland's adult committal prison (the first prison someone would go to from court) and began to hold non-paramilitary remand and short-term sentenced prisoners. It held separated paramilitary prisoners from Loyalist and Republican backgrounds since 2003. With the closure of the women's prison in 2004, the Mourne complex was developed primarily into a centre for life sentenced prisoners approaching tariff expiry. Braid House in the Mourne complex opened in 2008 and provided an additional 130 rooms. The Donard Centre in the main prison, which opened in 2011, ran activities for at risk prisoners. In late 2012, Quoile and Shimna houses opened in the main prison providing an additional 203 spaces. Meanwhile, in April 2014, Burren House re-opened on the site of the old Belfast prison. This was used to test life sentenced prisoners in a low security setting during their reintegration into the community.

Short description of residential units

Maghaberry main site

Bann House*	Up to 130 prisoners, including those in the first night and induction unit and short-term prisoners.
Bush House	Up to 141 prisoners, mostly vulnerable and Loyalist separated men.
Erne House*	Up to 130 mostly determinate sentence and life sentence prisoners and a small number on remand. Landings 1 and 2 were not in use.
Foyle House*	Up to 130 mostly remand prisoners and a number of sentenced men.
Glen House	Up to 28 prisoners.
Lagan House*	Up to 130 mostly remand prisoners.
Moyola House	Up to 19 prisoners, predominantly older and disabled men and those involved in high profile cases.

Quoile House	Up to 163 prisoners held on four landings: Donard (for at risk prisoners), a drug free landing and one housing prisoners involved in training and employment and education.
Roe House	Up to 144 prisoners, consisting of a mixed population and Republican separated prisoners.
Shimna House	Up to 40 prisoners in trusted roles.
Segregation unit	Up to 27 prisoners.

Mourne complex

Braid House	Up to 122 mostly life sentence prisoners and a small number whose custody had been extended and the Families Matter programme.
Martin House	Up to 12 prisoners held for their own protection.
Wilson House	Up to 42 prisoners serving life sentences.
Burren House	Up to 23 prisoners, used for life sentenced prisoners in the (Belfast city centre) community pre- and post-tariff.

** Denotes the 'square' houses*

Name of governor/director
Phil Wragg.

Escort contractor
In-house – Prisoner Escort and Court Custody Service (PECCS).

Health service provider
South Eastern Health and Social Care Trust.

Learning and skills provider
Belfast Metropolitan College.

Independent Monitoring Board chair
Patrick McGonagle.

Inspection Report

1 Executive Summary

Safety

S1 **At our last inspection of Maghaberry in May 2015 we rated outcomes in safety as poor overall.** The prison was not stable, processes to manage poor behaviour were ineffective and urgent action was needed to strengthen leadership. We called for an independent investigation of the serious fire at Erne House. We also considered care of vulnerable prisoners to be inadequate.

S2 **At this inspection we found that some progress had been made in addressing our concerns.** Urgent action had been taken to strengthen leadership, which was now focused on stabilising the prison. A review of the Erne House fire had been completed and lessons were being learned. Some progress had been made in tackling the challenges around safety, and there were credible plans to do more. Nevertheless, a significant amount of work was still outstanding to make Maghaberry safer and for this to reflect more positively in prisoners' experiences.

S3 PECCS had carried out surveys and met with prisoners to identify and tackle prisoners' concerns about escorts. Action was being taken to address underlying issues. Reception processes were mainly efficient but interviews were still not carried out in private. There were well advanced plans to address this. A Peer Supporter had recently started working in reception. First night procedures focused on settling men in and keeping them safe, but cells remained poorly equipped and many had extensive graffiti. Access to drinking water during the night had improved but not to hot water. Induction still needed improvement.

S4 A review of the circumstances around the Erne House fire had been completed and a number of recommendations made. It was planned that these were to be implemented over the coming months.

S5 Levels of violence were still too high and many prisoners told us they did not feel safe. The Security Committee had started to scrutinise safety issues but a more strategic approach was needed to manage the challenges in violence reduction. Integration between safer custody and other key departments needed to improve. Patrolling and supervision of yards and communal areas on the square houses had commenced, with plans to extend this to all residential areas. This was a very positive start. Investigations into allegations of assault by staff on prisoners were poor and needed urgent management attention.

S6 The Prisoner Safety and Support Team (PSST) and the Donard Centre provided a caring approach to many vulnerable prisoners and those in crisis, with improved health care input. There remained a need to develop a comprehensive safer custody strategy to better manage the significant challenges presented by an increasingly vulnerable population. There was better coverage of Listeners across the Maghaberry site, but still some delays in access.

S7 The strategic management of security was improving and the analysis and use of intelligence was developing well. There was a local security strategy and evidence that key security challenges specific to Maghaberry were being identified and assessed. Security-led meetings were given a high priority and attendance was improving but links with health care and safer custody remained weak. Illicit drugs and diverted medication were still readily available across the prison and this was contributing significantly to issues around control and safety. The Mandatory Drug Test (MDT) process was now well managed.

S8 It was very positive that a major refurbishment of the segregation unit had begun but conditions in some cells in the temporary unit were grim. Monitoring of segregation and governance of special accommodation remained inadequate but there were credible plans to improve this. The mental health needs of some segregated prisoners had not been assessed and were not being met. The prisoners in long-term segregation remained of concern. Use of force had reduced but was still high. Some aspects of governance had improved, but overall it was still insufficient.

S9 Clinical care for prisoners with drug treatment needs had deteriorated; new arrivals not on methadone prescriptions in the community were not provided with opiate substitution treatment. In contrast, psychosocial support had improved overall. There was better support for alcohol misusers and a reduction in some waiting times. Tradable medication was given in-possession too often, which continued to fuel its illicit use.

Respect

S10 **At the last inspection we rated outcomes in respect as poor overall.** The demands of the separated units were undermining the work of the whole prison. We were not assured that there was equal treatment for all prisoners, particularly Catholic men and those with disabilities. Health care services required urgent improvement to ensure patient safety.

S11 At this inspection we found that attention had been given to reducing the impact of the separated prisoner units on the rest of the prison, but this remained challenging and complex. Support for disabled prisoners had improved but more needed to be done to meet the needs of all the protected groups and Catholic prisoners. Some aspects of primary health care had improved but mental health provision had deteriorated and needed urgent attention.

S12 In our survey, prisoners remained very negative about many aspects of respect and decency. The newer units were bright, clean, spacious and fit for purpose. Efforts had been made since our last inspection to improve the square houses and they were more decent, although overall they remained poor quality accommodation.

S13 Maintaining the regime for separated prisoners which included commitments about minimal curtailment and enhanced staffing levels was still impacting on the rest of the prison. The recent introduction of a staff rotation and support scheme in the separated units was a positive step.

S14 Fewer prisoners in our survey were satisfied with relationships with staff than in 2015 although most said they were treated respectfully. As at the last inspection, the majority of staff–prisoner interactions were respectful, but somewhat distant. Many staff had low expectations of those in their care. House consultation forums had been introduced, but had yet to be embedded.

S15 Overall the promotion of equality and diversity had seen limited progress. The disparity in outcomes for Catholic prisoners across many areas remained unchanged. There was now better and more consistent identification of those with disabilities and some good support was provided. Forums for older prisoners were now held and some good work with foreign nationals continued. There remained little acknowledgment of the needs of some other minority groups. Processes for reporting and investigating diversity complaints still needed improvement.

S16 The faith needs of most prisoners were being met although access to corporate worship was still problematic for some.

S17 The complaints system was better organised and more prisoners said it was easier to make a complaint, though fewer believed the system to be fair. The number of complaints had increased and a large proportion of this related to dissatisfaction with accommodation. Eighty percent of outstanding complaints had been addressed, which was a major achievement, though there were still over 300 remaining.

S18 The new SEHSCT senior team was motivated to improve the health care service. Staff said there had been greater engagement and leadership from senior managers and that dialogue was now more open.

S19 Staffing levels in primary care had improved. Monitoring and implementation of chronic disease management had improved. Long delays in prisoners receiving their medication had reduced but more work on this was required. The provision of secure storage for in-possession medication had commenced and some spot checks were undertaken. Medicine administration had improved on most houses. Prisoners could still wait up to seven months for a routine dental appointment which was far too long. The Trust needed to review the closure of the inpatient unit to reflect the changing demographic and to ensure the needs of prisoners were effectively met. Mental health services had deteriorated since the last inspection and this was negatively impacting on the care of patients.

S20 Prisoners remained negative about the food and although meals were now served at more appropriate times, supervision was inadequate and prisoner perceptions were poor. Tuck shop provision remained reasonable.

Purposeful activity

S21 **At the last inspection we rated outcomes in purposeful activity as poor.** We assessed learning and skills provision as inadequate and in need of urgent improvement.

S22 At this inspection we found reasonable progress had been made in the learning and skills provision. More prisoners were attending activities and achievements were increasing. Too many men were still without any activity and curtailment of the regime was significant, although reducing. The new core day was starting to support a better focus on delivering a more purposeful and stable regime.

S23 It was positive that a universal core day had been implemented since our last inspection. This allowed for prisoners in full-time work to achieve over nine hours a day out of cell. Slightly fewer men than at our last inspection were locked up during the working day. Staffing shortages were still impacting on delivery of the regime. Monitoring of the regime had improved and whilst curtailments were still frequent, they were more predictable and reducing.

S24 More effective strategic planning and joint working between the Belfast Metropolitan College and the NIPS was enhancing opportunities for prisoners to undertake good quality activities. There was a need to improve the communication and collaboration between all of the learning and skills staff to develop the provision further. Collection and use of data was improving, as was self-evaluation but both needed further work. There had been a significant increase in the number of prisoners engaged in activities. Nevertheless, too many men still had no activity and not all the opportunities available were being used.

S25 The curriculum offered remained too narrow and some aspects of provision were not planned coherently or sufficiently aligned to the Northern Ireland economy. The number of prisoners on accredited courses had increased but attendance needed to be better.

S26 Initial assessment of prisoners' essential skills needs had improved but this process needs to be extended to capture and record all aspects of their prior learning, achievements and experience in their individual learning plans. The information in these plans needed to reflect prisoners' learning, skills and personal development more fully and be linked to sentence plans. There were still limited opportunities to gain vocational qualifications beyond level 1. Progression to level 2 and higher was poor. The arrangements for the assessment, delivery and accreditation of the essential skill of numeracy had improved. However, the delivery of literacy and ICT still needed to improve. Opportunities to study for GCSE qualifications in English and maths needed to be developed to enhance prisoners' opportunities to further or higher education and training. The assessment and planning for the English for Speakers of Other Languages (ESOL) provision required significant improvement and the arrangements for external accreditation required immediate attention. A good start had been made in linking prison job roles to accredited qualifications. The quality of the teaching, training and learning observed was mostly good.

S27 The provision for learning through the Open University was being adversely affected through changes to delivery and support arrangements, particularly the restricted access to ICT. The provision continues to be constrained reducing further the prisoners' access to qualifications beyond level 1.

S28 Library services had improved, with an increased range of fiction materials available and additional support for the prisoners to develop their educational interests. Other improvements included the opportunity for prisoners to read and record children's stories to maintain important home links and an initiative to provide mentorship for those prisoners who wished to learn to read.

S29 The physical education provision remained good and opportunities for older prisoners and those with disabilities had improved. Access to the gym during the weekends had become increasingly restricted. As a consequence, attendance at gym sessions had decreased by approximately 20% since the same period last year.

Resettlement

S30 **At the last inspection we rated outcomes in resettlement as reasonably good** but recommended that provision should be based on a robust needs analysis of the population.

S31 **At this inspection we found that progress had been made in better understanding the needs of the population,** although this had not yet been fully embedded in what was being delivered. Offender management arrangements remained reasonably strong and through-the-gate support remained generally good.

S32 The resettlement needs analysis data was becoming more meaningful, but it was not yet informing commissioning decisions about resettlement services. The Prisoner Development Unit (PDU) was still very short of staff, but there were now advanced plans to fill vacancies. There was still a need to improve links between the PDU and other departments, such as education. Temporary release continued to be used frequently to maintain family ties and to support resettlement objectives.

S33 Prison Service Sentence Managers were now completing release planning work for low and medium-risk prisoners. This demanded more risk management expertise than previously, and they were not yet confident in this work. Most eligible prisoners continued to have sentence plans and regular contact with Sentence Managers. Risk of harm assessments were routinely present, and reviewed at key points. Public protection arrangements remained generally sound, but we were concerned that some risks to the public not covered by the Public Protection Arrangements Northern Ireland framework were being missed. Categorisation processes had improved. Indeterminate sentence prisoners with more than three years to serve still needed more support. Burren House continued to provide good opportunities through-the-gate for lifers.

S34 Short-term prisoners received little proactive support although they could self-refer to relevant agencies. Good reintegration support was provided to higher risk prisoners.

S35 Some reasonable support was being offered in the resettlement pathways although more could be done to publicise provision to prisoners. Careers advice and guidance support still needed to be better.

S36 Overall children and families provision remained strong. In contrast to the last inspection, visits started on time and visitors were complimentary about their treatment by staff.

S37 A good range of offending behaviour programmes was still being delivered. It was good to see that advanced plans were in place to hold twice yearly 'celebrations of success' that would include family involvement.

Appendices

Appendix 1: About this inspection

Her Majesty's Inspectorate of Prisons (HMIP) is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, immigration detention facilities and police custody. Criminal Justice Inspection Northern Ireland (CJI) is an independent statutory Inspectorate, established under the Justice (Northern Ireland) Act 2002, constituted as a non-departmental public body in the person of the Chief Inspector. CJI was established in accordance with Recommendation 263 of the Review of the Criminal Justice System in Northern Ireland of March 2000.

All inspections carried out by HMIP and those prison inspections jointly carried out with CJI contribute to the United Kingdom's response to its international obligations under the Optional Protocol to the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HMIP and CJI are two of several bodies making up the NPM in the United Kingdom.

The Education and Training Inspectorate (ETI) is a unitary Inspectorate, and provides independent inspection services and information about the quality of education, youth provision and training in Northern Ireland. It also provides inspection services for CJI, of the learning and skills provision within prisons, in line with an agreed annual Memorandum of Understanding and an associated Service Level Agreement.

The Regulation and Quality Improvement Authority (RQIA) is a non-departmental public body responsible for monitoring and inspecting the quality, safety and availability of health and social care services across Northern Ireland. It also has the responsibility of encouraging improvements in those services. The functions of the RQIA are derived from The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

Appendix 2: Inspection team

Brendan McGuigan	Chief Inspector, Criminal Justice Inspection Northern Ireland (CJI)
Martin Lomas	Deputy Chief Inspector, Her Majesty's Inspectorate of Prisons (HMIP)
Sean Sullivan	Team leader, HMIP
Dr Ian Cameron	Inspector, CJI
Colin Carroll	Inspector, HMIP
Paul Fenning	Inspector, HMIP
Jeanette Hall	Inspector, HMIP
Gordon Riach	Inspector, HMIP
Paul Tarbuck	Inspector, HMIP
Karen Dillon	Inspector, HMIP
Francesca Cooney	Inspector, HMIP
Dr Tim McSweeney	Researcher
Catherine Shaw	Researcher
Sophie Skinner	Researcher
Alissa Redmond	Researcher
Patricia Taflan	Researcher

Specialist inspector

Paul Roberts	Substance misuse Inspector

Health and learning and skills were inspected by a team of 10 Inspectors from the RQIA and seven Inspectors from ETI respectively.

Appendix 3: Recommendations from the last inspection report

Recommendation 1

Urgent and decisive action should be taken to strengthen the leadership of the prison. The leadership of the prison must:

- provide visible reassurance and authority to staff and prisoners;
- reduce staff absenteeism;
- ensure basic safety processes are in place to address the concerns outlined in this report;
- ensure a security strategy relevant to the needs of the prison is developed and implemented in a co-ordinated way across all relevant departments;
- prioritise the delivery of a predictable and decent regime; and
- take robust steps to reduce availability of illicit drugs, to prevent the abuse of divertible medication and ensure the administration of prescribed medicines is carried out to Nursing and Midwifery Council standards and is fully supported by the SEHSCT's and NIPS' operations and regimes.

Recommendation 2

The Department of Justice should commission an independent inquiry into the causes and management of the fire at Erne House and what lessons can be learnt for the future. The inquiry should identify any misconduct or neglect by responsible individuals and action should be taken accordingly.

Recommendation 3

If it is necessary to continue to manage the separated units in line with different criteria from the rest of the prison, their location, management and resources should be removed from the rest of the prison in order to prevent their significant adverse impact on the prison population as a whole.

Recommendation 4

A comprehensive strategy to reduce the level of self-harm and self-inflicted death should be developed with a named manager responsible for its implementation. Priorities should include:

- ensuring all prisoners are placed in decent first night accommodation and receive an appropriate induction;
- ensuring recommendations arising from previous deaths are implemented and procedures to reduce the risk of suicide and self-harm are fully followed;
- SPAR *[Supporting Prisoners at Risk]* case management procedures should focus on understanding and responding to the underlying causes for prisoners' distress;
- access to Listeners' should not be unnecessarily restricted; and
- convicted and unconvicted prisoners should not have to share cells.

Recommendation 5

Managers should ensure that:

- effective measures are in place to monitor and oversee the use of all disciplinary processes, use of force and segregation;
- poor behaviour is challenged promptly and proportionately by all staff;
- issues underlying poor behaviour are identified and tackled;
- all staff are up to date in the necessary training;
- all prisoners are screened by managers and health care staff prior to being segregated and their safety and welfare is reviewed on a daily basis thereafter; and
- the segregation regime for longer stay prisoners should be adequate to mitigate any resulting psychological deterioration.

Recommendation 6

The prison should investigate and address the reasons for the poorer outcomes for Catholic prisoners, put in place arrangements for the effective and credible investigation of discrimination complaints and consult with prisoners with disabilities and other minority groups, to ensure their needs are understood and met.

Recommendation 7

Within one month of receipt of this report, the SEHSCT and the NIPS should submit an action plan setting out the steps required to address the concerns identified in the report including measures to:

- provide reassurance that partnership arrangements between the HSCB *[Health and Social Care Board],* the SEHSCT and the NIPS are effective, understand and address the concerns of staff, develop sustainable clinical governance arrangements and rapidly improve standards of clinical care;
- maintain sufficient suitably qualified and experienced staff to meet the health care needs of the population;
- reduce waiting times;
- improve chronic disease management;
- implement screening and vaccination programmes;
- ensure all equipment and drugs are safe to use;
- improve the management of the administration of medications in line with Nursing and Midwifery Council standards. This should be fully supported by the SEHSCT's and NIPS' operations and regime;
- provide prompt reports on adverse incidents and replies to complaints;
- improve communicable disease management; and
- respond to the security risk identified regarding hospital appointments.

Recommendation 8

The leadership and management of learning and skills should be strengthened. There should be a robust quality improvement process informed by data analysis, to ensure that the learning and skills provision meets prisoners' resettlement and development needs.

Recommendation 9

The prison should complete a robust needs analysis of its population and ensure that the resettlement services provided meet the needs of the population.

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