The Prisoner Ombudsman for Northern Ireland

REPORT BY THE PRISONER OMBUDSMAN

INTO THE CIRCUMSTANCES

SURROUNDING THE DEATH OF

RICHARD BERNARD GILMORE

AGED 25

IN MAGILLIGAN PRISON

IN THE EARLY HOURS OF SUNDAY 11 JANUARY 2009

29 APRIL 2010

Please note that where applicable, names have been removed to anonymise the following report.

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PREFACE

Richard Bernard Gilmore was born on 26 June 1983. He was 25 years old when he died in his cell in Magilligan Prison, in the early hours of Sunday 11 January 2009.

I offer my sincere condolences to Richard's family for their sad loss. I have met with Richard's family a number of times and I have shared the content of this report with them and responded to the questions and issues they raised.

With the agreement of Richard's family, I refer to him throughout the report as Richard.

As a result of my investigation into Richard's death and emerging findings, I determined that there was a requirement to request input from an independent medical expert. I am grateful to Dr Peter Saul for carrying out a Clinical Review.

My report contains this preface and a summary followed by my recommendations, introduction and methodology, leading to my findings and supporting appendices.

My findings are presented in eight sections:

- Section 1: Events before 7 January 2009
- Section 2: Richard's Period of Temporary Leave from 7-9 January 2009
- Section 3: Events of 9 January 2009
- Section 4: Events of 10 January 2009
- Section 5: Incident Management after Richard's Death
- Section 6: Autopsy and Toxicology Report

- Section 7: Staff Training
- Section 8: The Management of Drugs in Magilligan Prison

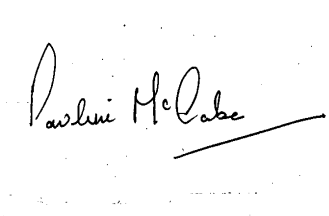
In the event that anything else comes to light in connection with the matters addressed in this investigation, I shall produce an addendum to this report and notify all concerned of my additions or changes.

As a result of my investigation, I make **31 recommendations** to the Northern Ireland Prison Service and the South Eastern Health and Social Care Trust. Fifteen of these recommendations were made on 1 July 2009. It was my view that implementation of these recommendations might help to prevent further serious incidents or deaths. I therefore decided that they should be notified in advance of the preparation of this report.

The recommendations cover:

- The supply and control of drugs at Magilligan.
- The response to serious incidents.
- The management of prisoner drug abuse.

Thank you to all those who co-operated in this investigation both from the Northern Ireland Prison Service, the South Eastern Health and Social Care Trust and other agencies. Their helpfulness was much appreciated.



PAULINE MCCABE
Prisoner Ombudsman for Northern Ireland
29 APRIL 2010

SUMMARY

Richard Bernard Gilmore was remanded into the custody of Maghaberry Prison on 7 August 2008. On 28 August 2008 he was transferred to Magilligan Prison and was given an early release date of 30 January 2009. Sadly he died in prison on 11 January 2009.

Richard had been in prison on previous occasions and prison health records show that he was known to have a long history of drug problems involving use of multiple substances as well as alcohol. When Richard arrived at Maghaberry on 7 August 2008, it was noted that he had previous drugs misuse behaviour which resulted in him accidentally overdosing in 2007. Richard was interviewed by a Governor and said that prior to entering Maghaberry, he was taking drugs such as cannabis, ecstasy and cocaine on a weekly basis.

Richard was transferred to Magilligan on 28 August 2008 and a nurse again recorded Richard's accidental overdose. Following this interview, Richard was assessed and, as he had been self administering his medicines at Maghaberry, he was approved for self medication. He was issued with his weekly supply of co-codamol, prescribed for shoulder pain.

Richard appeared to settle into prison life and a number of officers in Magilligan Prison commented in Richard's Personal Officer Reports[1] that Richard was: *"polite and respectful to staff and conforms to all wing routines without question."*

On 12 September 2008, Richard passed a voluntary drug test. All prisoners are expected to be drug free, however, drug free accommodation is available to prisoners who agree, as part of the

[1] Personal Officer Reports – Personal reports which monitor the progress of prisoners in respect of them conforming to the prison regime.

conditions of residing in the accommodation, to take and pass voluntary drug tests. On 16 September 2008, Richard was moved to the drug free accommodation in H1 A and B.

On 25 September 2008, during the Joint Committal and Discharge Interview, which prisoners with less than four months to serve attend to discuss resettlement needs, Richard admitted that the use of alcohol and drugs had caused him problems and he requested a referral to the Drug and Alcohol Team based at Magilligan. The referral was received by the team on 3 October 2008 and Richard was assessed on 23 October 2008. At the assessment interview, however, Richard declined any offer of help, stating that he had been clean of drugs for a period of time and that, because he had a partner and child, he was more settled and looking forward to his release to be with them. Richard was adamant that he was finished with drugs and didn't need any further help.

It was, however, the case that Richard had taken a further drug test on 10 October 2008, which showed that he had taken a non prescribed drug. The result of the test was received at the prison on 30 October, after his meeting with the member of the Drug and Alcohol Team on 23 October. Test results were not routinely notified to the Team.

Conditional upon passing the drugs test on 10 October Richard, having successfully met the other criteria, was put forward for promotion from Standard to Enhanced level, within the Progressive Regimes and Earned Privileges Scheme[2] (PREPS).

[2] PREPS – Progressive regimes and Earned Privileges. There are three levels of regime - Basic, Standard and Enhanced. The purpose of the PREPS system is to increase participation in constructive activities, encourage good behaviour and thus prepare prisoners for release. This is achieved by rewarding those prisoners who engage positively.

As a result of his failed drug test, Richard was demoted back to Standard level of the PREPS scheme and was also removed from the drug free wing of H1 A and B to accommodation in H1 C and D.

In a telephone conversation on 20 December 2008, Richard discussed with a friend that the reason that he had been moved was not because of the prescribed painkillers the prison doctor had given him, but *"for a different type of painkiller"* he had taken.

On 17 November 2008, Richard had surgery to remove a plate from his shoulder and was discharged from hospital, to continue with his prescription of co-codamol. On 27th November 2008, Richard complained of increased shoulder pain and his co-codamol was stopped and substituted with Tramadol, a more powerful pain relieving medicine.

The clinical reviewer, Dr Peter Saul, when examining Richard's medication record noted that the drug recording system at Magilligan made it difficult to correlate drugs prescribed and issued. The South Eastern Health and Social Care Trust have subsequently advised that they have taken steps to address this difficulty.

Prisoners coming to the end of their sentence may apply for short periods of temporary release and Richard was granted two days of home leave from 7 to 9 January 2009.

One of the conditions for Richard's home leave was that he had to take a voluntary drug test, which he took on 6 January 2009 and passed.

All prisoners entering or leaving the prison, including those on home leave, are processed through reception. All prisoners undergo a full body search, which includes the removal of clothing and use of metal

detection apparatus. Following the full body search, prisoners returning to prison put on clothing left in reception ready for their return. This process helps to reduce the risk of any items concealed within clothing entering the prison.

Richard was processed through reception when he left Magilligan Prison on 7 January 2009 and again when he returned on 9 January 2009. There is no indication that staff were suspicious that Richard was bringing in any prohibited articles or substances on his return from his home leave, and no prohibited articles were discovered during the search process.

At interview, however, a prisoner said that, "*Richard returned from Home Leave on the Friday before he died and he brought back with him 200 plus of loyalist blue tablets[3], 100 plus white Subutex tablets[4] and about 2-3oz of cannabis. I know that he managed to bring this quantity of drugs in his back passage in Kinder Egg containers.*"

It was also established that, after the news of Richard's death had been released in the press, the security department in Magilligan Prison received a phone call from a fellow prisoner, who was out on temporary release. The prisoner stated that Richard had brought in *"D10's/ Roche 10's and Subutex"* when he returned to Magilligan Prison from his home leave.

The prisoner who phoned Magilligan Prison further stated;

"The news had suggested a bad batch of drugs had been the cause, however it was the amount that Richard had taken. Richard had been under pressure to bring drugs into the prison and the drugs that he had

[3] Loyalist Blues – Are often diazepam 10mg tablets and are blue in colour. However, they can also contain ecstasy (MDMA) and ketamine, a short acting but powerful general anaesthetic which has powerful hallucinogenic qualities.
[4] Subutex – Contains the active ingredient buprenorphine.

taken were the ones he had brought into prison from his recent home leave."

It was not possible to confirm whether pressure was being placed on Richard to bring drugs back into prison. The prison service is well aware that prisoners who are granted temporary leave can be vulnerable to such pressure.

On his return from home leave on 9 January 2009, Richard undertook a voluntary drug test, which was a condition of his temporary release contract. On 15 January 2009, after Richard's death, the result of this test was available and showed positive for cocaine, but no other substances.

Following his return from home leave, CCTV observations on 9 January 2009 show Richard interacting and socialising with a number of fellow prisoners throughout the day.

Entries on the wing journal suggest that the remainder of the day was largely uneventful, with no reference to any suspicion of drugs being on the wing. At interview, however, a night custody officer who was on duty that evening said that, during the handover from day staff, she was provided with information to suggest that there may have been drugs on the wing. The night custody officer could not recall which officer provided her with this information and the handover was not, as required by Prison Service policy, recorded in the wing journal.

The drug related information provided by day staff was not, as required by Prison Service policy, recorded and forwarded to the Security Department.

At interview the night custody officer stated that, that evening, she identified a number of cells she suspected of drugs misuse and that

she believed that a number of prisoners were *"off their faces"* on drugs. One of these prisoners was Richard. The night custody officer stated that she could smell prohibited substances being smoked in various cells and she seized an improvised smoking device in the ablutions area at 21.05.

In line with Prison Service policy, the night custody officer recorded on a security information report (SIR), what had occurred and submitted this to the Security Department at the end of her shift.

At interview, the night custody officer further stated that there was "*camaraderie"* between Richard and another prisoner she suspected of drug taking that night. This was observed when Richard spoke to another prisoner through a cell door as Richard went to and from the ablutions area. There was, however, no record of this information in the wing or senior officer journals as a reference for future shifts.

At approximately 09.20 the next morning, 10 January 2009, Richard spoke to a nurse officer and requested his weekly prescription of co-codamol. Prescriptions are only permitted to be requested on a Friday and as it was a Saturday, the nurse officer refused Richard's request. At interview, the nurse officer advised that Richard was not happy with this and insisted that it was Friday. The nurse officer then checked Richard's prescription records and noted that he should have had 32 tablets remaining from his most recent issue. She requested that Richard provide her with the tablets he had left and found that he only had 10 tablets. The nurse officer retained the tablets and notified Richard that he would now be placed on daily issue of medication and that she would be giving him an adverse report[5] for this medication abuse.

[5] Adverse report – Bad behaviour reports which can affect the regime level the prisoner is on.

The nurse officer had no further dealings with Richard that day and was not aware of any concerns about Richard's well being.

As a result of the security information report submitted by the night custody officer, the security department made arrangements for a search to take place on the morning of 10 January 2009. The search involved two cells in H1 D wing and two cells in H1 C wing. One of these cells was Richards. The search team planned the searches to coincide with the routine lock down of the wing for cleaning. This was to avoid arousing the suspicion that would have resulted from an unscheduled lock down.

At 09.29, CCTV shows officers on the wing commence cell lockdowns. Eight minutes after the locking of the cells commenced, Richard was finally locked at 09.37. During this time, CCTV shows Richard talking to other prisoners and entering other cells, including one of the cells that was also going to be searched. When leaving this cell, Richard and the other prisoner who was about to be searched, can be seen walking out of the camera's view. They remained out of the camera's view for approximately one minute. Due to the angle of the CCTV camera, it is unknown whether Richard walked into the ablutions area or onto C wing with this other prisoner. Prisoners can move between C and D wing.

The exact time of arrival of the search team at the building is unknown, but it may or may not be the case that Richard was aware of the search team's presence prior to being locked down. CCTV would suggest that the length of time taken to lock down the wing could have provided an opportunity for Richard and the other prisoner to conceal or dispose of any prohibited substances they possessed.

No drugs were found on Richard or in his cell and no drugs were found on his wing. There was, however, drugs found on C wing.

When asked about Saturday 10 January 2009, a prisoner on Richard's wing, said:

"From the time Richard came back off home leave he was off his head. He was slurring his words and wobbling all over the place when he was moving about the wing. On the Saturday during the day, a number of cells were searched, one of which was Richard's. Those officers should have noticed at that point that he wasn't well and should have observed him more frequently or seen a medic. Richard was taking drugs steady from when he came back and was handing them out to a few of his mates also."

Observation of the CCTV does not appear to show Richard *"wobbling all over the place when he was moving about the wing"*. Richard looks as though he is walking normally.

The officers who searched Richard that day stated that there was no evidence of Richard being under the influence of drugs.

However, at interview, one of the officers who was working on H1 C and D wing on 10 January 2009 said:

"I interacted with him (Richard) and quite a few other prisoners on a regular basis and on the day that he, on that Saturday, he was unsteady on his feet and he was, from what I can remember, slurring his words. He had spoken to a medical officer (nurse) first thing in the morning."

The officer added that Richard was "*a very up and down sort of character and that on some days he would have spoken to you and other days he wouldn't bother.*" He said that "*on that day he was certainly ….. more off his head than other days he had been.*"

In the absence of the nurse who had seen Richard raising any concerns, the officer did not feel the need to take any further action.

Other officers who interacted with Richard that day stated that he seemed the same to them and there was nothing untoward to note about his demeanour or mannerisms.

Throughout the course of this investigation a number of members of staff stated that the misuse of drugs in Magilligan Prison is common. They said that to increase the observations of all prisoners suspected of misusing drugs would not be possible due to the extra staff that would be required to achieve this.

CCTV for 10 January 2009 shows Richard moving around the wing. There is a lot of activity in his cell and the cell opposite, with several prisoners coming and going.

At 12.02, Richard collected his lunch from the dining hall and took it back to his cell. Lunch time lock down was between 12.46 and 13.59. During the afternoon Richard was moving around the wing and associating with different prisoners.

From 15.41 Richard stayed in his cell, not leaving it again before his death. Several prisoners can be seen entering and leaving the cell until lockdown. Tea was served at 16.00, but Richard did not receive his meal. Between tea being served and lock down, there was further movement of prisoners in and out of Richard's cell and two officers can be seen speaking to the occupants of Richard's cell on separate occasions.

CCTV shows that at 17.21, all cells were checked and locked down for the night and the night time sanitation system commenced, requiring

prisoners to use their in cell call buttons when needing to use the ablutions.

On the night of 10 January 2009, H1 had one officer working in the control room and two officers supervising both C and D wings where Richard was located.

At 19.20, one of the night custody officers came on duty and, in line with Prison Service policy, commenced a body check to ensure that all prisoners were in their cells and accounted for. During this body check the night custody officer found a prisoner passed out on the floor of his cell. His cell was unlocked immediately. Medical attention was administered and the prisoner was later taken to hospital by ambulance.

One of the night custody officers who dealt with the incident explained at interview that, having found the prisoner unconscious, officers *"shouted to other prisoners like 'has he taken anything? What has he taken? What'll help him?' and someone shouted – I forget what he said but it was two types of drugs."*

CCTV shows the officer looking into a number of cells. When asked why, he said that it may be that these were the prisoners who may have spoken up about what drugs the prisoner had taken. One of these cells was Richards.

Prison Service policy requires that checks must be carried out on prisoners at 19.30 and 07.00 and staff must be satisfied that prisoners are alive by seeing their faces and observing movement, even if it means waking them. Other checks must be carried out at specified times during the night to confirm that a prisoner is in his cell, but there is no requirement to ensure that signs of life can be seen.

Richard's family wanted to know *"Why were there not increased observations on the wing that night,"* over and above the checks required by this order, as a result of a prisoner having been found unconscious. The investigation found that night custody officers, on 10 January 2009, did take it upon themselves because of the earlier incident, to conduct an extra body check requiring a response from prisoners, at 21.12.

CCTV of this body check shows that the night custody officer who checked Richard at 21.12 looked through the cell door flap and kicked Richard's cell door. At interview, the night custody officer stated that whilst he could not recall anything untoward, the fact that CCTV shows him kicking Richard's cell door, would suggest that Richard was already in his bed. He said that, as a result of him kicking the door, Richard must have provided a response before he moved onto the next cell.

The next check was at midnight and did not require a sign of life to be seen. The night custody officer who carried out this check said that he could not recall anything specific about Richard during the check.

CCTV does not show Richard's cell alarm light illuminating, indicating that he needed to use the ablutions or requested assistance, at any time during the evening.

After the midnight check, the next scheduled body check was at 02.00. As with the check at midnight the purpose of this was to check that there was a person in the cell. There was no requirement to ensure that there was a sign of life.

CCTV shows that a different night custody officer carried out this check from the officer who carried out the midnight check. At 02.11

the night custody officer can be seen kicking Richard's cell door for approximately one minute and walking back down the landing.

In his statement, the officer said that he could not see any movement. He said that the covers were up over Richard as he lay on his bed and the only part of Richard that was visible was his left temple area and his left eyebrow. The light in Richard's cell had been left on and there was liquid spilled on the floor. The night custody officer stated that the combination of all these things raised his suspicion that something wasn't right. He further stated that he kicked the door and called Richard's name a couple of times and got no response.

At approximately 02.12, the night custody officer left the wing to alert the Emergency Control Room via the block controller of his concerns.

In an emergency situation, Prison Service policy requires that a cell door should be opened immediately, providing two officers are present. In any other situation when the cells are locked down, there is a requirement to have three officers present. The night custody officer who checked Richard at 02.11 said that he didn't see the situation as an emergency, because prisoners do sometimes lie as still as possible when officers are trying to wake them up. He further stated that he didn't class what he saw as an obvious life threatening situation, such as "*seeing someone hanging, the sight of blood or in the obvious case, as with the prisoner earlier that night, a prisoner collapsed on the floor.*"

It took 11 minutes from the night custody officer finding Richard unresponsive to when the senior officer and nurse officer arrived at Richard's cell to unlock it. During this time CCTV shows both night custody officers returning to Richard's cell and kicking and looking through the cell door to try and obtain a response.

At interview the senior officer and nurse officer said that they were both in the Old Hospital Building[6] when the Emergency Control Room notified them that they had an unresponsive prisoner in H1. Both officers stated that the main cause of their delay in getting to H1 was the time it took for the nurse officer to access Richard's medical history on the computer system. The nurse officer stated the reason for doing this was to see if Richard had any clinical history which could account for him being unresponsive.

The clinical reviewer, Dr Peter Saul, concluded that given that the nurse had been told that Richard was unresponsive, the decision to access his clinical history before attending him was a reasonable one.

At 02.23, Richard's cell was opened and the senior officer and nurse officer entered his cell. The senior officer stated that when he pulled back Richard's duvet, Richard's face was a purple/blue colour. The nurse officer further stated that Richard's pupils were unresponsive to light and that she could not find a pulse. She was unable to insert an airway into Richard's mouth, due to his teeth being clenched, but immediately commenced CPR[7] and oxygen therapy with the assistance of one of the night custody officers.

In his report the clinical reviewer, Dr Peter Saul, said that given the clinical findings that Richard was blue, had no heart beat and was stiff with clenched teeth it was his view that Richard had been dead for some time prior to the officers discovering him.

Dr Saul concluded that:

"Mr Gilmore's treatment had been appropriate. In this case earlier entry to the cell is unlikely to have made any difference but might in other

[6] Old Hospital Building – A new healthcare centre is used for treating prisoners. The old hospital building is used for administration purposes only.
[7] CPR - Cardiopulmonary resuscitation is an emergency procedure for people in cardiac arrest or, in some circumstances, respiratory arrest.

circumstances. It is impossible to determine the time of death other than to say that Mr Gilmore is likely to have been dead at the time of discovery."

On manoeuvring Richard to a position which enabled CPR to be conducted, the night custody officer who was assisting the nurse found a plastic yellow Kinder Egg container lying on the bed behind Richard. Within the container were some tablets wrapped in bubble wrap.

CPR continued until the paramedics arrived at Richard's cell at 02.47. The nurse officer advised that the paramedics attached leads to Richard and hooked them up to their equipment. A heart trace was carried out, but no response was obtained and no further medical assistance was given to Richard. The paramedics left at 03.13.

It is usually the case that the chief medical officer would attend to confirm a death, but on this occasion the chief medical officer was out of the country. As a result, the police duty medical officer was requested to attend. She attended at 05.08 and due to this delay Richard's time of death was recorded as 05.12.

Richard's mother had asked why her son was not safe in prison, from the misuse of drugs.

The management of the supply and use of drugs presents a major challenge to prisons everywhere. The Governing Governor at Magilligan Prison is committed to trying to keep Magilligan Prison drugs free. At the same time, wherever possible, he does not want to introduce measures which disadvantage or appear to punish prisoners and visitors who never abuse drugs. This balance can, at times, be difficult to achieve.

As part of this investigation, the management of various issues in connection with drugs, that had relevance to Richard, were examined.

The therapeutic work of the Drugs and Alcohol Team was noted and it was also noted that Magilligan has a Drugs Steering Group. A comprehensive monthly analysis of data including drugs finds, drug related adjudications, deployments of the passive drugs dogs and prisoners and visitors who have restrictions placed on their visiting arrangements because of being suspected of possessing drugs, is carried out and informs decision making.

Some concerns were, however, identified in respect of the treatment of drugs free wings, drug testing arrangements, the operation of the PREPS scheme, the action taken by staff who believe that prisoners may have taken drugs, the security of the visits area, the communication of drugs test results and the use of mobile phones. These are discussed in Section Eight and many of my early and current recommendations result from these findings.

RECOMMENDATIONS

As a result of my investigation I make 31 recommendations to the Northern Ireland Prison Service. A number of the recommendations relate to the provision of healthcare and are, therefore, made to the Prison Service and the South Eastern Health and Social Care Trust (SEHSCT).

Many of these recommendations result from the information presented in Section 8 of the report which examines Drugs Management Issues.

I shall request updates on the implementation of these recommendations in line with the action plan provided by the Prison Service.

EARLY RECOMMENDATIONS MADE ON 1 JULY 2009

Recommendation 1

I recommend that the Prison Service ensure that random voluntary drug testing is extended to cover all standard prisoners in Magilligan Prison.

(Note: The Prison Service accepted this recommendation and advised that from 13 July 2009, voluntary drug testing would be offered to all prisoners irrespective of regime level. The Prison Service advised that they could not currently require prisoners to provide a urine sample, but that this would change in Autumn 2009 when Prison Rules would be changed to provide enabling powers for the Prison Service to introduce mandatory drug testing.

On 1 February 2010, new Prison Rules came into effect to introduce compulsory testing for illegal drugs and alcohol.)

Recommendation 2

I recommend that the Prison Service ensure drugs free wings are required to be drugs free and that any prisoner failing a drugs test, or found with drugs, is immediately required to leave the wing. I do support the view that prisoners, removed from the wing for failing a drugs test, should be given every support to get back to the drugs free wing as soon as possible.

(Note: The Prison Service accepted this recommendation stating that there are two hundred and fifty cells across Halward House, Sperrin, Alpha and Foyleview which are set as a progressive regime within a drug free environment. They said they have zero tolerance for the presence of drugs and failure of drugs tests.

The Prison Service further said that prisoners are transferred from these areas if they fail drug tests but that they have regular reviews and case conferences to provide the opportunity for prisoners to demonstrate progress and facilitate their return to drug free accommodation, including Foyleview.)

Recommendation 3

I recommend that the frequency of random drugs testing of prisoners located in the drugs free wings, where prisoners have the benefit of a new modern facility, should be reviewed to ensure that the likelihood of maintaining a drugs free environment is maximised.

(Note: The Prison Service stated that further consideration was needed because using the current urine drug testing procedures, they have finite staff resources and limited time to carry out drug tests due to the pressures of managing an ever increasing prisoner population. The Prison Service further stated that an increase in drug testing in any area of the prison would currently have to be based on intelligence and prisoner behaviour.

The Prison Service stated that with the anticipated introduction of saliva (swab) testing at the end of 2009, the above limitations should not be an issue. Saliva testing has not yet been introduced but information has been sought on the revised plans for its implementation.)

Recommendation 4

I recommend that the Prison Service should introduce the new 'Swab Test' for obtaining voluntary drug test samples, which is easy to administer and provides results much sooner.

(Note: The Prison Service stated that they anticipated the introduction of the new swab (saliva) testing procedures by the end of 2009. Saliva testing has not yet been introduced but information has been sought on the revised plans for its implementation.)

Recommendation 5

I recommend that Magilligan Prison introduce a system whereby failed drug test results are always notified to Healthcare. I extend this recommendation to all Northern Ireland Prison Establishments, where relevant.

(Note: The Prison Service accepted this recommendation stating that currently failed drug tests are recorded on PRISM, however, they have agreed that failed drug tests will be notified to Healthcare.

Further to this, the South Eastern Health and Social Care Trust stated that historically, healthcare did not get sight of failed drugs tests but they have put new procedures in place to receive all failed drug test results.)

Recommendation 6

I recommend that the Prison Service introduce a system whereby failed drug tests are notified to the Offender Management Unit. I extend this recommendation to all northern Ireland Prison establishments, where relevant.

(Note: The Prison Service accepted this recommendation stating that currently failed drug tests are recorded on PRISM, however, they have agreed that failed drug tests will be notified to the Offender Management Unit.).

Recommendation 7

I recommend that the Prison Service take steps to ensure that Officers fully record in the wing journals, details of information supplied to or requests directed to Security Staff, which would provide important information impacting on the duty of care provided by officers across subsequent shifts.

(Note: The Prison Service stated that it is not appropriate to record all sensitive information in a wing journal which might be seen by prisoners. However, information of a sensitive nature which impacts on security, good order and control within the residential area should be

recorded in the Residential Manager's journal and should be available to other managers who can then brief their staff accordingly. The Prison Service, in addition, stated there is a well established Security Information Reporting System which allows staff to provide information to Security directly.

The Prison Service further stated that staff coming on duty should be briefed by the managers on any developments which occurred during the previous shift.

In light of this, I have made a further recommendation in respect of shift handover arrangements. (See recommendation 21)

Recommendation 8

I recommend that the Prison Service take steps to ensure that the results of searches are also recorded in the wing journal in order that staff are fully informed about substances found.

(Note: The Prison Service stated that it is not appropriate to record information in the wing journal. Such information should only be recorded in the residential manager's journal and should be available at shift hand-overs.)

Recommendation 9

I recommend that Magilligan Prison carries out a review into how cell searches are planned and monitored in order to minimise the opportunity for drugs to be concealed or disposed of.

(Note: The Prison Service stated that cells are routinely searched by residential staff. However, where there is specific intelligence to

suggest that there is a significant problem in a specific area, a special search will be organised. This does require time to plan, given the requirement to organise staff as Magilligan does not have a dedicated staff search team.

The Prison Service further stated that every effort is made to ensure intelligence led searches are conducted without prisoners being aware, but inevitably when staff appear at the block in large numbers, prisoners will quickly become aware that something is about to take place. They will then make whatever efforts they can to dispose of contraband, which includes both swallowing and inserting drugs in body cavities.

I repeat my recommendation for a review to take place. This should include consideration of the role that landing staff can play in prioritising lock down of the prisoners to be searched.)

Recommendation 10

I reiterate a previous recommendation that the Prison Service should install approved technology to block the use of mobile phones in all prisons.

(Note: The Prison Service have advised that there are issues in regard to legislation, financial constraints and capability of current technology to block mobile phone signals regardless of network or wavelength. Tests carried out on blocking mobile phones have revealed concerns in regard to radiation levels and range of cover.

I note current research the Prison Service are undertaking in respect of this and would recommend that appropriate decisions are made at the earliest opportunity.)

Recommendation 11

I recommend that the Prison Service research, at the earliest opportunity, the feasibility of using mobile phone detectors which are currently available on the market.

(Note: The Prison Service has availed of the opportunity to purchase a limited number of mobile detectors and indeed mobile, local blockers.)

Recommendation 12

I recommend that the Prison Service carry out a review of the level of supervision of prisoners on a wing following a serious incident of drugs misuse and that this should not rely on Landing Officers/ Night Custody Officer using their discretion.

(Note: In response, the Prison Service stated that it would be impossible to be prescriptive to cover all situations. They further stated that supervising staff are required to use their discretion to introduce additional checks where this is considered necessary and that it is also right that the night custody officers use their discretion to carry out further checks if they have a specific concern.

Whilst I support the requirement for staff to be fully responsible and vigilant in such a situation, I am still recommending that the requirement for extra checks should be stated in Prison Service policy and included in staff training.)

Recommendation 13

I recommend that arrangements should be put in place for informing prisoners when a serious drug related incident has occurred, and for prisoners to be given the opportunity, and

encouraged, to come forward with any information or concerns they may have without any repercussions.

(Note: In responding to this recommendation, the Prison Service said that this is already accepted practice, depending on the seriousness of an incident. The Prison Service further stated that Magilligan Prison has advised prisoners of drug "amnesties" on several occasions in the past.

In light of the response to the suspected overdose on 10 January 2009, I am recommending that, following such an incident, officers should speak with each prisoner on the relevant landings and record and pass to a senior officer and healthcare staff any information provided to them. I note also that whilst prisoners were all checked for a sign of life after Richard's death, they were not woken and spoken to.)

Recommendation 14

I recommend that Magilligan Prison carry out a review of the adequacy of security in the area where visitors move between the security area and the main visits room.

Recommendation 15

I recommend that Magilligan Prison carry out a review on the current arrangements for prisoners leaving the Visits Room.

(Note: In response to these recommendations, the Prison Service accepted them stating that plans are well advanced to provide an extension to the existing visiting facility. The Prison Service further stated that Magilligan Security will review the existing security arrangements, in particular the monitoring of movement in the area

between the security area and main visiting area to ensure there is adequate CCTV cover and any improvements will be brought forward as part of the refurbishment work.

FURTHER RECOMMENDATIONS

Recommendation 16

I recommend that Magilligan Prison review the use of their Dry Cells in the Special Supervision Unit to provide staff with the option of placing prisoners in a Dry Cell in line with Prison Rule 32 (1A) when they are suspected of concealing prohibited articles in body cavities.

Recommendation 17

I recommend that Magilligan Prison ensure that all staff involved with prisoners on a daily basis are reminded of their duty to submit Security Information Reports as soon as they suspect any activity related to the misuse of drugs.

Recommendation 18

I recommend, as identified by the training manager in Magilligan Prison, that specific written instructions for emergency 'unlock' procedures (other than fires) for Sperrin, Alpha, and Foyleview accommodation are prepared and circulated.

Recommendation 19

I recommend that Magilligan Prison replace the faulty and technically unsupported CCTV systems within the H-Blocks.

Recommendation 20

I recommend that Magilligan's Chief Medical Officer is required to notify the Emergency Control Room when he/she will not be available to attend emergency incidents, and to indicate where emergency requests should be directed.

Recommendation 21

I recommend that Magilligan Prison takes action to ensure that an appropriate and recorded handover takes place between day and night shift staff and that this should include the communication of any concerns about the availability or use of drugs, which should have been notified and recorded in the residential manager's journal. I extend this recommendation to all Northern Ireland Prison establishments, where relevant.

Recommendation 22

I recommend that Magilligan Prison review the policy and guidelines defining all of the action that should be taken where staff believe that prisoners behaviour suggests that non prescribed drugs may have been used. This should include a review of the role and expectation of healthcare staff. The outcome of the review should be communicated to all staff and included in staff induction and training arrangements.

Recommendation 23

I recommend that Magilligan Prison, in line with Prison Service policy, remind staff that all body checks must be recorded in the night guard journals.

Recommendation 24

I recommend that Magilligan Prison and the SEHSCT review the arrangements for achieving entry to a cell where there is an unresponsive prisoner and possible serious health concerns.

Recommendation 25

I recommend that Magilligan Prison and the SEHSCT put in place arrangements for discussing failed drugs tests with prisoners with a view to developing an appropriate plan. The plan should be recorded and should include any action required in respect of prescribed medication, self medication and referral to drugs counselling services and any problems or issues that may be increasing the likelihood of drugs abuse. I extend this recommendation to all Northern Ireland Prison establishments, where relevant.

Recommendation 26

I recommend to Magilligan Prison and the SEHSCT that arrangements should be put in place to ensure that self medication assessments should take account of previous addictive behaviour, episodes of self harm and results of drug tests.

Recommendation 27

I recommend to Magilligan Prison and the SEHSCT that drugs tests that are passed are also notified to healthcare in order that healthcare can identify any circumstances where prescribed medication is not evident in a test result, implying that a prisoner may not be taking his medication correctly.

Recommendation 28

I recommend to the Prison Service and the SEHSCT that they carry out an audit to ensure that the new medication recording booklet has been fully implemented.

Recommendation 29

I recommend that the Prison Service and SEHSCT ensure that everyone involved in a death in custody is in attendance at the cold de-brief.

Recommendation 30

I recommend that the Prison Service carry out a further assessment of the possible value of using the B.O.S.S chair already located at Maghaberry Prison. (See page 133 for further information in respect of B.O.S.S chairs)

Recommendation 31

I recommend that the Prison Service comprehensively audit the implementation of the Prison Service Action Plan produced in response to the recommendations of the Report on Minimising the Supply of Drugs in Northern Ireland Prisons produced in July 2008.

INTRODUCTION TO THE INVESTIGATION

Responsibility

1. As Prisoner Ombudsman[8] for Northern Ireland, I have responsibility for investigating the death of Richard Gilmore in Magilligan Prison in the early hours of 11 January 2009. My Terms of Reference for investigating deaths in prison custody in Northern Ireland are attached as Appendix 1.

2. My investigation as Prisoner Ombudsman provides enhanced transparency to the investigative process following any death in prison custody and contributes to the investigative obligation under Article 2 of the European Convention on Human Rights.

3. I am independent of the Prison Service, as are my investigators. As required by law, the Police Service of Northern Ireland continues to be notified of all such deaths.

Objectives

4. The objectives for my investigation into Richard Gilmore's death are:

   - to establish the circumstances and events surrounding his death, including the care provided by the Prison Service;

   - to examine any relevant healthcare issues and assess the clinical care afforded by the Prison Service;

[8] The Prisoner Ombudsman took over the investigations of deaths in prison custody in Northern Ireland from 1 September 2005.

- to examine whether any change in Prison Service operational methods, policy, practice or management arrangements could help prevent a similar death in future;

- to ensure that Richard's family have the opportunity to raise any concerns that they may have and that these are taken into account in my investigation; and

- to assist the Coroner's inquest.

Family Liaison

5. An important aspect of the role of Prisoner Ombudsman dealing with any death in custody is to liaise with the family.

6. I first met with Richard's family on 9 February 2009 and was grateful for the opportunity to keep in contact with them on further occasions to update them on the progress of the investigation. I also met with them again recently in order to explain and discuss the findings and recommendations within this report.

7. It was extremely important for my investigation to learn more about Richard and his life from his family. I thank Richard's family for giving me the opportunity to talk with them about Richard and the circumstances of his tragic death.

8. Although my report will inform many interested parties, I write it primarily with Richard's family in mind. I also write it in the trust that it will inform policy or practice which may make a contribution to the prevention of a similar death in future at

Magilligan Prison or any other Northern Ireland Prison Service establishment.

9. Along with many other issues, I took forward the concerns raised by Richard's family. In particular, the family asked the following questions:

- Why was their son not safe in Prison from the misuse of drugs?
- Why was there not increased observations on Richard's wing on the night of his death, given that two other prisoners had been taken to outside hospital that day with suspected drug related problems?
- Was everything that could have been done to save Richard's life carried out?
- Did Richard try to raise the alarm for assistance and if so, did he get the necessary attention?
- Was anyone aware of him being sick and if so, what subsequent action was taken?
- Why was Richard on a wing which was known as a "drugs" wing?
- What medical treatment did Richard receive and from whom?
- Is it possible that, at the 02.00 check on 11 January 2009, movement was seen that was in fact Richard having a fit?

INVESTIGATION METHODOLOGY

Notification

10. In the early hours of Sunday 11 January 2009 I was notified by the Prison Service about Richard's death in Magilligan Prison.

11. A member of the Ombudsman's investigation team attended Magilligan Prison at 06.35 on 11 January 2009 to be briefed about the series of events leading up to and following Richard's death.

12. The investigation into Richard's death began on Monday 12 January 2009 when Notices of Investigation were issued to Prison Service Headquarters and to staff and prisoners at Magilligan Prison, inviting anyone with information relevant to Richard's death to contact the investigation team.

Notice to Prisoners

13. No prisoners came forward in response to the Notice to Prisoners sent out on 12 January 2009. During the course of the investigation, however, accounts were obtained from prisoners who spoke to Richard in the days before he died.

Prison Records and Interviews

14. Magilligan Prison was visited by the investigation team on numerous occasions and investigators met with prison management, staff and prisoners. All the prison records relating to Richard's period of custody, including his medical records were obtained.

15. Interviews were carried out with prison management, staff and prisoners, in order to obtain information about the circumstances surrounding Richard's death.

Telephone Calls

16. The investigation team listened to telephone calls made by Richard from 20 December 2008 to 10 January 2009, in order to establish whether any information in the calls was relevant to the circumstances of Richard's death.

Magilligan Prison, Prison Rules and Policies

17. Background information on Magilligan Prison and a summary of Prison Rules and Procedures referred to in the report are attached at Appendix 2.

Early Recommendations

18. As a result of the initial enquiries into Richard's death by the investigation team, it was deemed appropriate to share a number of observations with, and make recommendations to, the Prison Service in advance of this report.

19. It was my view that action in respect of these recommendations could impact upon the risk of a similar death occurring and as such it would have been inappropriate to wait for the production of the final investigation report. The early letter, detailing the recommendations made, is attached as Appendix 3.

Autopsy & Toxicology Report

20. The investigation team liaised with the Coroners Service for Northern Ireland and were provided with the autopsy and toxicology reports.

Clinical Review

21. As part of the investigation into Richard's death, Dr Peter Saul, GP Associate Postgraduate Dean at Cardiff University, was commissioned to carry out a clinical review of Richard's healthcare needs and medical treatment whilst in prison and the medical attention he received on the night that he died. I am grateful to Dr Peter Saul for his assistance.

22. Dr Peter Saul's clinical review forms an important part of my investigative report and it informed some of my findings and recommendations. The findings of his review report are included, as appropriate, at relevant points in the report, along with the response from the South Eastern Health and Social Care Trust.

Working together with interested parties

23. An integral part of any investigation is to work together with all the interested parties involved. To that end the investigation team liaised with the Police Service of Northern Ireland.

HM Inspector/Other Reports

24. Previous recommendations made to the Northern Ireland Prison Service by the Prisoner Ombudsman and/or the Criminal Justice Inspectorate which are relevant to the circumstances surrounding Richard's death, have been considered and, where relevant, referred to within this final report.

Factual Accuracy Check

25. I submitted my draft report to the Northern Ireland Prison Service and South Eastern Health and Social Care Trust for a factual accuracy check.

26. The Prison Service and Trust responded with a list of comments for my consideration. I have fully considered these comments and made amendments where appropriate.

FINDINGS

SECTION 1: EVENTS BEFORE 7 JANUARY 2009

1. Richard's Committal Process and Referral to the Drug and Alcohol Team

Part of the process for identifying alcohol or substance misuse problems takes place at the point of committal to prison.

Richard had been in prison previously. Prison health records show that he was known to have a long history of drug problems involving multiple substances including cannabis, cocaine, ecstasy and "speed[9]", as well as problems with alcohol.

All new committals undergo a full screening process where individuals are requested to provide a wide variety of information, including details of substance misuse. On 8 August 2008, during his committal to Maghaberry Prison, Richard stated at his Governor's interview that, prior to entering prison, he was taking drugs such as cannabis, ecstasy and cocaine on a weekly basis.

Richard was also seen by a nurse officer at the time of his committal and it was recorded that Richard had previously misused drugs and that he had accidentally overdosed in 2007. Richard was questioned about whether he had any current feelings of self harm and he stated that he did not.

Richard was transferred to Magilligan Prison on 28 August 2008 and underwent a transfer interview, similar to his committal interview at Maghaberry. A "prisoner on transfer" medical note

9 "Speed" – A street name for amphetamine.

accompanied Richard when he was transferred to Magilligan which noted his shoulder complaint and a previous accidental overdose. Following this, Richard was assessed by the nurse and approved for self medication. He was, therefore, receiving his prescribed medication on a weekly basis.

Medication for and Treatment of Shoulder Problem

On committal, Richard was suffering from pain in his shoulder due to an old injury. Richard was prescribed co-codamol for pain relief and was receiving 56 tablets per week, with the instruction to take two tablets four times a day. On 17 November 2008, Richard had a surgical plate removed from his shoulder.

On 27 November Richard was complaining of increased shoulder pain so the co-codamol was stopped and substituted by a more powerful pain relieving medicine called Tramadol, for a period of time.

Referral to Drug and Alcohol Team

On 25 September 2008, during his Joint Committal and Discharge Interview[10], Richard admitted that the use of alcohol and drugs had caused him problems and requested a referral to the Drug and Alcohol Team. The Drug and Alcohol Team are based in the Offender Management Unit in Magilligan Prison. At the time of Richard's death, the team was made up of counsellors from Northlands[11] and prison officers who have

[10] Joint Committal and Discharge Interview – An interview undertaken by the resettlement team when a prisoner has less than 4 months of their sentence to serve to identify any resettlement needs.
[11] Northlands – An independent alcohol and drug treatment centre which in 2000 joined a project in Magilligan to offer support to prisoners with drug and alcohol issues.

been trained to offer a range of programmes, to help rehabilitate prisoners with identified alcohol and drug related issues.

It was established that the Drug and Alcohol Team received a referral for Richard on 13 October 2008 and Richard was later assessed and interviewed by a member of Team on 23 October 2008. At that stage, however, Richard declined any offer of help and stated to the person who interviewed him, that he had been clean of drugs for a period of time. Richard further advised that he had a partner and child and he was more settled and looking forward to his release to be with them. He was adamant that he was finished with drugs and didn't need any further help.

In spite of what Richard had told the member of the Drug and Alcohol Team, he had in fact taken and failed a voluntary drug test on 10 October 2008. Due to a request by the drug testing company for information about Richard's prescription medication, the result of the test was not finalised and notified until 30 October 2008. The failed drug test was, in line with Prison Service policy, recorded on the service's database PRISM, which the Drug and Alcohol Team could access. The result was not, however, available at the time of Richard's interview with the team and would not have, routinely been drawn to the attention of the Drug and Alcohol Team when it was received.

1a. During Richard's committal interview at Maghaberry on 8 August 2008, he notified the Governor that he was taking drugs on a weekly basis.

1b. During Richard's resettlement interview on 25 September 2008 at Magilligan, Richard requested a referral to the Drug and Alcohol Team.

1c. On 23 October 2008, during his assessment interview with the Drug and Alcohol Team, Richard declined their offer of support services, stating that he had been off drugs for a period of time.

1d. Richard failed a voluntary drug test taken on 10 October. The results were not available when Richard met the Drug and Alcohol Team.

2. Richard's Medication

A Summary of Richard's Medication

The following is a summary of the prescribed drugs administered to Richard at various times between 8 August 2008 and January 2009:

- Minocycline, an antibiotic used to treat acne and not likely to be subject of abuse.

- Co-codamol 30/500, a medium strength analgesic containing a substantial dose (30mg) of codeine and which is known to induce habituation, maximum daily dose is 8 tablets.

- Tramadol 50mg, a moderate to strong synthetic opiod analgesic.

- Zopiclone 7.5mg, a hypnotic indicated for short courses to treat periods of sleep disturbance, and also for acne.

Laxative drugs were also prescribed.

Observations of the Clinical Reviewer

Richard was allowed to self administer his drugs. In his Clinical Review Dr Peter Saul said: *"The initial decision to allow self administration was very difficult in Mr Gilmore's case. He was clearly 'at risk' by way of previous addictive behaviour and an*

episode of accidental self-harm, but he had previously been self-administering."

Dr Saul also noted that there appeared to be some anomalies in the prescribing record of co-codamol for Richard. It would seem that more co-codamol was issued during the last four weeks of Richard's life than were prescribed.

Dr Saul found that the way that information is recorded on the prescription records makes it difficult to correlate drugs issued with those prescribed. He said that his best understanding from the records is that the last prescriptions recorded for co-codamol were on 17/11/08 for 56 tablets (one week's supply) and 28/12/08 for 56 tablets. The following were subsequently issued to Mr Gilmore:

- 19/11/08 56 tablets
- 27/11/08 2 tablets
- 30/12/08 56 tablets
- 6/01/08 56 tablets

Response from the South Eastern Health and Social Care Trust

In response to a review of the Clinical Review Report completed by Dr Saul the Trust provided the following comments:

"Dr Saul describes anomalies in the prescribing and issuing of co-codamol. Following a check through Richard's medicine administration record, the Healthcare Manager can confirm that Richard received the correct amount of medication prescribed."

The Trust further advised that during the Christmas period, additional stock is ordered to store in locked cupboards to ensure that prisoners do not have gaps in the administration of their medication. Electronic prescriptions are generated and sometimes there is an overlap in these to ensure a supply is readily available to administer on the correct date.

The Trust advised that in Richard's case he was prescribed the following:

19.11.08	Seven days issued
26.11.08	No supply
27.11.08	Two tablets issued; if Richard's supply had run out, as would appear to be the case, the nurse would have given him medication from the emergency stock until the GP prescribed more.
27.11.08	GP prescribed two weeks of Tramadol – he was issued with a week's supply that evening.
11.12.08	A further week supply of Tramadol prescribed and issued
18.12.08	Two weeks supply of Tramadol prescribed
19.12.08	Only 12 days issued. Sometimes supplies of medications run out and Boots send the prison 'owing' slips. Once supplies are back in stock the prison receives the rest of the prescription. It would appear that Richard was not then given the remaining 3 days of Tramadol, as he was issued a week's supply of co-codamol on the 30.12.08 and 6.01.09.

In previous Prisoner Ombudsman Death in Custody investigations, it was recommended that a review be carried out of the current drug chart system in order to try and bring clarity to the drug administration process. In February 2009, the Prison Service advised that a review of all aspects of the current medication recording system had been completed in November 2008. They further advised that, following this review, a new medication recording booklet was to be designed and piloted over a six month period. Following evaluation, should the findings be positive, the Prison Service stated that full implementation would follow.

2a. Richard was allowed to self administer his medicines. He had a previous history of addictive behaviour but had been self administering before coming to Magilligan.

2b. The clinical reviewer, Dr Peter Saul, recorded in his report that the current drug chart system makes it difficult to correlate drugs issued with those prescribed.

2c. A previous Prisoner Ombudsman death in custody investigation recommended that a review be carried out to try and bring clarity to the drug administration process.

2d. In February 2009, the Prison Service and South Eastern Health Care Trust commenced a six months pilot on a new medication recording booklet.

3. Progressive Regimes Earnings and Privileges Scheme & Voluntary Drug Testing

On 8 August 2008, as part of Richard's committal process he was provided with details of the Progressive Regimes and Earned Privileges Scheme (PREPS), along with a guidance leaflet.

PREPS works towards its stated objectives by allocating privileges according to different regime levels. Privilege and regime levels are based on a three tier system of Basic, Standard and Enhanced.

On committal, all prisoners start at Standard level and can be put forward for promotion to Enhanced level based on their engagement with their resettlement plan, behaviour towards staff and other prisoners and adherence to prison rules.

Prisoners must also have a clear disciplinary record for at least three months, be willing to take and pass a voluntary drug test and agree to random testing thereafter.

On 12 September 2008, Richard passed a voluntary drug test and was subsequently moved to H1 A and B wing, which at the time was a designated Drug Free Wing. (The term *'drug free wing'* is explained in Section 8 of this report.)

On 9 October 2008, having successfully met the requirements, Richard was promoted to the Enhanced level, subject to passing a further voluntary drug test.

On 10 October 2008, Richard took a voluntary drug test which proved to be positive for opiates and buprenorphine. Both of these substances can be found in prescribed medicines and, as a result, the laboratory requested further information to verify whether or not the substances found in Richard's sample were consistent with any prescribed medication he was taking.

Details of Richards prescription was provided to the drug testing laboratory and, following analysis of this information, the result of his drug test showed abuse of a buprenorphine based drug not consistent with his prescribed medication. Opiates found in the sample were consistent with the co-codamol Richard had been prescribed.

On 30 October 2008, following notification of the results of his drugs test, Richard was demoted in regime from Enhanced to Standard and removed from the designated drug free wing of H1 A and B, to the standard accommodation of H1 C and D.

In a telephone conversation on 20 December 2008, Richard discussed the reasons for the move to another wing with a male friend. The friend said to Richard that he thought the failed drug test was due to painkillers the doctor had given Richard. In his response, Richard laughed and told his friend that the reason he was moved was not because of the painkillers the doctor had given him, but *"for a different type of painkiller"* he had taken.

The investigation considered whether Richard may have been taking other pain relief medication because his prescription medication was not meeting his pain needs. A review of Richard's medical file and other related material, gives no

indication that Richard ever requested extra pain relieving medication, over and above that prescribed.

In-possession Medication

The Northern Ireland Prison Service In-Possession Medication Policy (September 2008) states *"The purpose of this policy is to ensure that a prisoner is assessed appropriately on their ability to store and manage their own prescribed medicines safely."*

Healthcare staff are required to carry out in-possession risk assessments on all prisoners considered for in-possession medication. The policy states, *"the risk assessment can only provide a snap shot of risk at a particular point in time."* As part of the ongoing monitoring of this process the responsibility to carry out "*regular monitoring checks with patients to establish whether the patient is managing their own medicine safely and that there is no medication misuse such as hoarding or trading"* lies with the healthcare/ nurse officers.

Richard failed his drug test on 30 October 2008. The result of the test provided evidence that Richard had been taking drugs other than those prescribed to him. There is no evidence that this drug test failure was notified to healthcare or triggered a further risk assessment in respect of the appropriateness of self administering.

In his Clinical Review Report, Dr Saul, noting that the drug test taken on 10 October 2008 showed the presence of buprenorphine which indicates that Richard may have been taking illicit supplies whilst in prison, concluded:

"There was therefore a clear warning sign that Mr Gilmore was using non prescribed drugs, If Healthcare staff had been aware of this then it should have led to a review of the safety of allowing self-administration of the prescribed drugs."

Dr Saul added *"but even if drugs had been administered under supervision during his entire stay in prison there is no certainty that the outcome would have been different."*

In response to Dr Saul's conclusion, the Trust confirmed that healthcare staff had not been informed of the failed drug test.

3a. On 9 October 2008, Richard was promoted to the Enhanced regime on the understanding that he had to pass a voluntary drug test.

3b. On 10 October 2008, Richard provided a sample for the voluntary drug test.

3c. On 30 October 2008, Richard was notified that he had failed his drug test and was demoted to the Standard Regime and removed from the designated drug free wing of H1 A and B wing to the standard accommodation of H1 C and D wing.

3d. There is no evidence that this drug test failure was notified to healthcare or triggered a further risk assessment in respect of the appropriateness of self administering.

SECTION 2: RICHARD'S PERIOD OF TEMPORARY LEAVE FROM 7 - 9 JANUARY 2009

4. Pre-Release Home and Resettlement Leave

Prisoners coming to the end of their sentence may apply for short periods of temporary release. The amount of leave granted is governed by the length of time a prisoner has been in continuous custody. Pre-Release leave is treated not as a right, but as a privilege to be earned by the individual.

Richard was eligible for two days home leave which was granted from 7 to 9 January 2009.

4a. Richard was allowed out of prison on home leave from 7 – 9 January 2009.

Reception process

All prisoners entering or leaving the prison, including those on home leave, are processed through reception. The reception process on return to prison includes the updating of photographic identification records and the removal of money brought back in for placement in a prisoner's personal account. Items brought back from home leave are registered in the prisoner's personal property account. A full body search is then carried out which includes the use of metal detection apparatus. Following the full body search, clothing that prisoners have left in reception in readiness for their return, is put on. This process helps to reduce the risk of any items, concealed within clothing, entering the prison.

The prisoner will either go back to their residential area or, in the case of a prisoner requiring a voluntary drug test, they will be placed in a clean area[12] to await transportation to the drug testing centre.

Richard was processed through reception when he left Magilligan Prison on 7 January 2009 and again when he returned on 9 January 2009.

There is no indication that staff were suspicious that Richard was bringing any prohibited articles or substances into prison on his return from his home leave and no prohibited articles were discovered during the search process.

At interview, however, a prisoner said that, "*Richard returned from Home Leave on the Friday before he died and he brought back with him 200 plus of loyalist blue tablets, 100 plus white Subutex tablets and about 2-3oz of cannabis. I know that he managed to bring this quantity of drugs in his back passage in kinder egg containers.*"

The investigation also established that, after the news of Richard's death had been released in the press, the security department in Magilligan Prison received a phone call from a fellow prisoner, who was out of prison on temporary release. The prisoner stated that Richard had brought in with him *"D10's/ Roche 10's and Subutex*" when he returned to Magilligan Prison from his home leave.

[12] Clean Area – An area which only holds prisoners re-entering the prison who have already been through the reception process and therefore should not have any unauthorised articles or substances in their possession.

The prisoner who phoned Magilligan Prison further stated:

"The news had suggested a bad batch of drugs had been the cause, however it was the amount that Richard had taken. Richard had been under pressure to bring drugs into the prison and the drugs that he had taken were the ones he had brought into prison from his recent home leave. Richard was taking 90% of the drugs he was bringing in."

It was not possible to confirm whether pressure was being placed on Richard to bring drugs back into prison. The prison service is well aware that prisoners who are granted temporary leave can be vulnerable to such pressure.

Roche 10's / D10's are a round blue tablet which go by the generic name of diazepam and are of 10 milligram strength.

Drugs referred to as "loyalist blues" are often diazepam 10 milligram tablets which, as stated, are blue in colour. However, it is also to note that these tablets may also contain ecstasy (MDMA) and ketamine[13].

Subutex tablets contain the active ingredient buprenorphine, which is a type of medicine called an opioid. Buprenorphine is an opioid that is used to wean people off their addiction to stronger opioids such as morphine, diamorphine (heroin) and methadone.

[13] Ketamine - A short-acting but powerful general anaesthetic which depresses the nervous system and causes a temporary loss of body sensation often used for operating on humans and animals. It also has powerful hallucinogenic qualities (with a distortion of objects and reality).

4b. No drugs were discovered when Richard was processed through reception on his return to prison following his home leave of 7 – 9 January 2009.

4c. Information from two prisoners suggests that Richard did bring drugs into prison and that these may have been hidden internally in Kinder Egg containers.

5. Concealing of Drugs in Body Cavities

At the time of the Report on Minimising the Supply of Drugs in Northern Ireland Prisons[14] it was documented that:

"There is evidence that the second most common way that drugs are smuggled into the prisons is by prisoners returning from periods of temporary release. Prisoners secrete the drugs in body cavities and thus are sometimes successful in defeating the full search arrangements."

The authority to search prisoners derives from the Prison Act, Prison Rules and Common Law. There is no provision for the authority to retrieve items concealed within body cavities.

Where an individual is suspected of concealing prohibited articles or substances, under Rule 32 (1A) of The Prison and Young Offenders Centres Rules (Northern Ireland) 1995, the individual can be restricted from association and placed in a special cell to monitor and secure any secreted articles the individual may be concealing.

A 'Dry Cell' is designed with limited furniture and no plumbed sanitation to allow secreted articles to be retrieved without being flushed away. Where fitted, in cell CCTV assists officers in the monitoring of prisoner's actions.

Magilligan Prison Governor's Order H7, Special Supervision Unit – Use of Dry Cells, dated 18 July 2008, states:

[14] In July 2008 the Prison Service researched and produced a report in response to the concern about increased drug related incidents and evidence of increased drugs misuse.

"Cell numbers 8 and 9 are designated as Dry Cells and contain no furniture, fittings or toilet facilities and are intended to be used for C & R (Control and Restraint) relocations for a very short period."

This Governor's order clearly indicates that the Dry Cells cannot be used for the purpose of placing a prisoner on Rule 32 (1A), to retrieve prohibited articles secreted in body cavities.

In any event, when Richard returned from home leave on 9 January 2009, staff did not suspect that he was carrying prohibited items and would not, therefore, have placed him in a Dry Cell even if this was an option.

5a. Magilligan Prison has two Dry Cells, but the Governor of Magilligan Prison has decided that they are only to be used for locating continually violent prisoners, for a very short period of time.

5b. When Richard returned from home leave on 9 January 2009, staff did not suspect that he might be concealing prohibited articles.

5c. Information received after Richard's death suggests that Richard did bring drugs into prison, following his home leave.

SECTION 3: EVENTS OF 9 JANUARY 2009

6. Richard's Movements on Return from His Home Leave

Day Time Activities – 9 January 2009

Richard returned from his period of home leave at 10.53 on 9 January 2009 and left the prison reception area at 11.36. At 11.45 Richard undertook a voluntary drug test which was a condition of his temporary release contract.

On 15 January 2009, after Richard's death, the result of this test was provided to Magilligan Prison and showed positive for cocaine, but no other substances.

CCTV observations on 9 January 2009 show Richard interacting and socialising with a number of fellow prisoners throughout the day.

Entries on the wing journal suggest that the remainder of the day was largely uneventful, with no reference to any suspicion of drugs being on the wing. The Security Department have confirmed that no security information reports were submitted that day to inform them of any concerns related to drugs being on the wing. At interview, however, the night custody officer who was on duty that evening said that, during the handover from day staff, she was provided with information to suggest that there may have been drugs on the wing.

At interview, the night custody officer could not recall which officer advised her of this information.

Night Time Activities - 9 January 2009

The handover briefing was not, in line with Prison Service policy, recorded in the landing journal, but it is likely that the handover took place between 20.10, when it is recorded in the journal that the officer came on post and 20.20 when it is recorded that the day staff were stood down.

At interview, the night custody officer said that, as a result of the information provided by a member of day staff, she was more observant of, and aware of, the prisoners' movements during night time sanitation[15].

The night custody officer further stated that she identified a number of prisoners that night that she suspected of drug misuse. She stated that this was due to the smell of prohibited substances being smoked in various cells and the seizure of an improvised smoking device in the ablutions area at 21.05. The night custody officer said that she recorded on a Security Information Report, that she believed a number of prisoners were *"off their faces"*. This was submitted to the Security Department at the end of her shift.

One of the prisoners identified by the night custody officer as possibly being involved in drug taking was Richard. The night custody officer was asked to explain why she believed Richard was one of the prisoners *"off their faces."* The officer advised that during night time lockdown, when the night time sanitation process is in use, prisoners are observed walking down the wing to go to the ablutions area. During the night the lights on the landings are dimmed but the officer recalled that when Richard

[15] Night Time Sanitation – The H Block cells in Magilligan Prison do not have toilets, therefore when the prisoners are locked down they can call their cell buzzer to be allowed to go to ablutions.

was unlocked to go to the ablutions area, the lights on the wing had to be turned up to see Richard better, as he was unsteady on his feet. The night custody officer stated that Richard wasn't unsteady on his feet to the point of "*actually raising a big alarm or anything,*" but she wanted to be able to see him better, as she suspected that he had been taking drugs in his cell.

At interview, the officer further stated that there was "*camaraderie*" between Richard and another prisoner she suspected of drug taking that night. Richard spoke to the other prisoner through his cell door when going to and from the ablutions area.

A print out of the night time sanitation unlocks shows that Richard was unlocked to attend the ablutions area for seven minutes between 00.44 and 00.51 on 10 January 2009.

The observations made by the night custody officer were recorded and forwarded to the Security Department in accordance with Prison Service policy. There was, however, no record of this information in the wing or senior officer journals as a reference for future shifts.

The Prisoner Ombudsman made an early recommendation on 1 July 2009 in connection with officer's fully recording important information in the wing journals. This is included in the recommendations section of this report on page 22, along with the Prison Service's response.

Night Time Cell Searches

The investigation team were informed that cell searches at night time are very difficult to organise, due to the reduced number of staff on duty. It was explained that, if staff were to be taken from other residential areas in order to assist in a search, the other residential areas would be left under staffed, which investigators were told could result in unacceptable security risks.

Normal practice is, therefore, to respond to security reports requiring cell searches, raised by night staff, the following day.

6a. Richard failed his drug test on return from home leave, but the result wasn't available until 15 January 2009.

6b. Some staff believed that a number of prisoners, including Richard, may have been taking drugs on 9 January 2009.

6c. Day staff did not inform the Security Department of their suspicions that there were drugs on the wing, but did tell a night custody officer.

6d. Night staff completed a Security Information Report reporting that a number of prisoners appeared to be using drugs.

6e. The information on the security information report was not recorded in a journal for future shifts.

6f. Normal practice is to respond to reports raised overnight, where cell searches are required the next day.

SECTION 4: EVENTS OF 10 JANUARY 2009

7. Richard's Interaction with a Nurse Officer

At 08.30 on 10 January 2009, Richard's wing was unlocked and he can be seen on CCTV walking down the wing shortly afterwards and associating with other prisoners.

At 09.15, CCTV shows Richard walking off the wing and then returning to the wing a couple of minutes later. At 09.19, CCTV shows Richard walking back off the wing holding a small white box, similar to a prescription box, and not returning until 09.25. Richard went to speak to the nurse officer during these times.

The nurse officer who saw Richard said:

"I recall prisoner Richard Gilmore came to the grill requesting his prescription drug which was co-codamol. I thought this was strange as I didn't have him on my list to be seen. When I went to the grill to speak to him he said he wanted to order his co-codamol. I told him there was no ordering on a Saturday and he told me it was Friday. When I advised him that it was Saturday he was still insistent and cheeky to me, stating it was Friday. Due to this I went back to my medical room and checked his Kardex[16] and noted that he should have 32 tablets left. As a result I went to the wing and asked staff to bring Richard out of his cell with his medication so that I could carry out a spot check. On review of his tablets in possession I noted that he only had 10 tablets remaining so I retained them and notified Richard I would be placing him on daily issue and giving him an adverse report for his medical abuse."

[16] Kardex – Personal Prescription Record

The nurse officer said that there was nothing in Richard's mannerism or demeanour that gave her any concern. She said that *"he just seemed as though he had got out of bed."*

The nurse officer further said that, due to the fact that she doesn't normally work in Richard's block, she wasn't familiar with him and therefore would not have known if he looked any different to any other day.

The adverse report completed by the nurse officer on 10 January 2009 stated:

"Prisoner presented this morning requesting co-codamol. I checked his records and he is not due his medication. I requested to see his medication and he had only 10 tablets left. I have informed him that this is medication abuse and he will be placed on a daily issue. I will be informing (the) doctor of this and have logged this on EMIS[17]."

Richard had previously been given a week's supply of medication at a time.

The nurse officer had no further dealings with Richard that day and said that no staff notified her of any concerns they had over Richard's well being.

7a. When Richard requested his repeat prescription for co-codamol the nurse officer was notified that Richard had only 10 tablets left when he should have had 32.

[17] EMIS – Electronic medical Information System used to keep a computerised record of each prisoners medical consultations and interventions with a nurse and doctor.

7b. The nurse officer took the rest of Richard's tablets and gave him an adverse report, and determined that his prescription medication should be administered on a daily basis.

7c. The nurse officer had no further dealings with Richard that day and no one informed her of any concerns about his well being.

8. Cell Searches on 10 January 2009

Magilligan Prison has search procedures in place designed to detect, deter and prevent drugs from entering the prison, as well as procedures for collating, evaluating and disseminating intelligence on drugs matters.

One method for gathering intelligence on drug matters is via Security Information Reports submitted by staff members.

Having received the drug related Security Information Report submitted by the night custody officer on duty on 9 January 2009, the senior officer in the security department said that he, "*assessed the information contained, as to its legitimacy and accuracy and formulated a search which included the provision of staff to enable the search to take place*".

The search involved two cells in H1 D wing and two cells in H1 C wing. One of the cells in D wing was Richard's.

At 09.29, CCTV shows officers on the landing begin to re-lock the wing. It was normal practice for the landing to be re-locked in order for cleaning to take place. The search leader advised that, in line with the routine lockdown of the wing for cleaning purposes, the search team *"planned to arrive following this lockdown to try and negate as much as possible prisoner knowledge of our presence to reduce the chances of prisoners secreting articles before searching commenced."*

Eight minutes after the locking of the cells commenced, Richard was finally locked at 09.37. During this time, CCTV shows Richard talking to other prisoners and entering other cells,

including one of the cells which was also going to be searched. When leaving this cell, Richard and the other prisoner who was about to be searched, can be seen walking out of the camera's view. They remained out of the camera's view for approximately one minute. It is not known, due to the angle of the CCTV camera, whether Richard walked into the ablutions area or onto C wing with this other prisoner. Prisoners can move between C and D wing.

The exact time of arrival of the search team to H1 is unknown, but it may or may not be the case that Richard had somehow become aware of the search team's presence prior to being locked down. The observations on CCTV could suggest that he may have. It may be that despite the efforts of the search team to prevent the prisoners knowing of their presence on the wing, the length of time taken to lock down the wing could have provided an opportunity for Richard and the other prisoner in D wing who was to be searched, to organise themselves and further conceal or dispose of any prohibited substances they possessed.

In his statement, the senior officer in charge of the searches said that a balance is required between allowing prisoners to go about their normal business during a routine lock down to try and eliminate any suspicions of a search about to take place and the need to protect the integrity of the search.

The Prisoner Ombudsman made an early recommendation on 1 July 2009 about all searches. This is included at the recommendations section of this report on page 22, along with the Prison Service's response.

Results of the Searches on 10 January 2009

Four cells on H1 C and D wings were searched on the morning of 10 January 2009 and prohibited substances were only found in one of the cells in C wing. Richard's cell was located on D wing. Whilst the cell searches were recorded in the Wing Journal, the results of the searches were not included.

The results of the cell searches were, however, recorded in the Residential Manager's Journal.

The Prisoner Ombudsman made an early recommendation on 1 July 2009 about the recording of results of searches. This is included at the recommendations section of this report on page 22, along with the Prison Service's response.

CCTV Monitoring of the Wings

CCTV on the wings can be viewed by the officer in the control room of each house, or via the prison's main Emergency Control Room. The cameras are on a consistent monitoring setting which allows them to continually sweep up and down the wings. The ability to manoeuvre the CCTV cameras onto a fixed point, or to follow an incident which is occurring, only lies with the officers in the Emergency Control Room, who have responsibility for the entire prison. This is because of a fault with the system.

ADT (the company who provides technical support for the CCTV systems across the Prison Service) conducted a review of all CCTV units across Magilligan Prison. The report indicates that all of the CCTV units in the H Blocks, where Richard's landing is located, are no longer supported by the manufacturer, are faulty and cannot be repaired.

The senior officer in charge of the searches on 10 January 2009 was asked whether the Emergency Control Room is used to monitor the actions on the wing (via CCTV) prior to or during the searches, in order for this information to be used to gather more intelligence. If CCTV had been monitored prior to the search of Richard's cell on 10 January 2009, it might, for example, have led to additional searching of the cells of other prisoners to whom Richard could have passed drugs.

The senior officer, in charge of the searches, stated that *"to target further individuals would have required further search teams that they could not provide given the constraints…… there were a very finite number of teams assigned in response to cells identified by the night custody officer."*

I note that a print out of searches at Magilligan shows that searches of all cells in C and D wings were carried out on 13 January 2009, two days after Richard's death.

The senior officer further stated that the use of the Emergency Control Room to monitor actions on the wing prior to or during the search would not generally happen as it would lead to an immense amount of radio transmissions between the search team and the Emergency Control Room which could be overheard by prisoners, so alerting them that something was in the offing.

He said also that the use of earpieces would not eliminate this problem because *"the person receiving the transmission MUST give a response which can be overheard."* The senior officer also stated that telephone conversations with the Emergency Control

Room would also not be practicable either *"because there still has to be liaison between the person on the end of the phone and the team which can be overheard."*

8a. As a result of the Security Information Report submitted by the night custody officer on 9/10 January 2009, planned cell searches took place on the morning of 10 January 2009.

8b. The cell searches were planned to coincide with the routine lockdown for cleaning to try and avoid making prisoners suspicious of an imminent search.

8c. The period of time taken to lock down the wing may have provided an opportunity for Richard to move or conceal drugs.

Search of Richard's Cell on 10 January 2009

At 09.57 on 10 January 2009, two officers entered Richard's cell for the purpose of carrying out a full search of Richard and his cell. Richard was searched for two minutes from 09.57 to 09.59. Following his full body search Richard was escorted to the dining hall at 09.59, while his cell was searched. One of the searching officers stated that Richard, "complied fully with all instructions given, answered any questions that were asked and was not overly talkative, but this would not have been out of character for him."

Richard was returned to his cell at 10.08.

No drugs were found on Richard or in his cell and no drugs were found on his wing.

8d. At the cell search on 10 January 2009, no drugs were found on Richard or in his cell.

9. Richard's Demeanour on Saturday 10 January 2009

In a statement obtained from a prisoner the following was noted:

"From the time Richard came back off home leave he was off his head. He was slurring his words and wobbling all over the place when he was moving about the wing. On the Saturday during the day, a number of cells were searched, one of which was Richard's. Those officers should have noticed at that point that he wasn't well and should have observed him more frequently or seen a medic. Richard was taking drugs steady from when he came back and was handing them out to a few of his mates also."

Observation of the CCTV does not appear to show Richard *"wobbling all over the place when he was moving about the wing"*. Richard looks as though he is walking normally.

The officers who searched Richard that day stated that there was no evidence that Richard was under the influence of drugs.

At interview, however, one of the officers who was working on Richard's wing on 10 January 2009, said:

"I interacted with him (Richard) and quite a few other prisoners on a regular basis and on the day he, on that Saturday, he was unsteady on his feet and he was, from what I can remember, slurring his words. He had spoken to a medical officer (nurse) first thing in the morning, shortly after unlocking, after the search."

CCTV shows Richard actually saw the nurse officer before the search took place.

The officer was asked whether any concerns had been raised by the nurse, or any instructions given to increase any observation of Richard. The officer said, *"Not that I can remember".*

The officer further stated, "*He was a very up and down sort of character and some days he would have spoke to you and other days he wouldn't bother and on that day he was certainly more, you know, maybe not a technical term to use but he was more off his head than any other days that he had been."*

It would appear that, knowing that Richard had seen the nurse, the officer did not feel that it was necessary to take any further action in relation to his suspicion that Richard had taken drugs.

Other officers who interacted with Richard that day stated that he seemed the same to them and there was nothing untoward to note about his demeanour or mannerisms.

Asked what they would do if they suspected a prisoner of taking drugs, the different officers on duty on 10 January 2009 said they would:

- *"inform the safer custody group and would observe the prisoner until he would be seen by a member of healthcare staff if it was deemed necessary and if the prisoner indicated any ill effects of this."*
- *"inform the Senior Officer and call a hospital officer to see the prisoner."*

- *"inform staff, hospital staff and the block Senior Officer...if they were an enhanced prisoner we could send him for a VDT (voluntary drug test)"*

Enquiries were made to ascertain the number of times staff have taken the above actions when they are concerned with the well being of a prisoner due to drugs, but unfortunately these are not recorded.

The healthcare manager advised that it would not be possible to ascertain how often healthcare staff are requested to attend drug related incidents because this would not be recorded in a prison journal for confidentiality reasons. This information would only be located in the individual's personal medical file and the electronic medical information system does not currently have the ability to audit this type of medical intervention.

The safer custody co-ordinator, whose role is to oversee how vulnerable prisoners on PAR1's[18] are managed, advised that there are number of reasons on PRISM[19] for PAR1's to be opened. He advised that "alleged overdose" is one of the reasons staff can select but is rarely used and the issue is being addressed as part of the introduction of the new SPAR[20] process.

The safer custody co-ordinator could, however, recall that, in September 2009, four prisoners were observed at 15 minute intervals because the night custody officers on duty were

[18] PAR1 – Prisoner At Risk booklet – records the reason for increasing the observations of vulnerable prisoners, details of case conferences held and a log to show the checks carried out. The checks can range from 15 minute observations to hourly observations.
[19] PRISM – The prison service database.
[20] SPAR – Supporting Prisoners At Risk – A means whereby staff can work together to provide individual care to prisoners who are in distress.

concerned that the prisoners' well being was at risk due to the misuse of drugs.

The voluntary drug testing unit were unable to provide details of how often staff request prisoners to be tested in connection with suspecting them of misusing drugs. The investigation team were, however, aware of staff making this request during the course of this investigation.

It was also the case that, during the investigation, a number of members of staff stated that the misuse of drugs in Magilligan Prison is common. They said that to increase the observation of all prisoners suspected of misusing drugs would not be possible due to the extra staff that would be required to achieve this.

9a. A prisoner said that from the time Richard came back off home leave he was slurring his words and wobbling all over the place when he was moving about the wing.

9b One officer who was on duty on 10 January 2009 stated that Richard was unsteady on his feet and more "off his head" than on other days.

9c. All of the other officers and a nurse who interacted with Richard on 10 January 2009 noted nothing that concerned them.

9d. CCTV observations do not show Richard appearing unsteady on his feet as he walks around the wing.

9e. There is evidence that some staff take appropriate action when they believe prisoners are using drugs but there is

also evidence that the rigour and consistency of approach may be variable.

10. Richard's Movements later on 10 January 2009

CCTV for 10 January shows Richard moving around the wing. There is a lot of activity in his cell and the cell opposite, with several prisoners coming and going.

At 12.02 Richard collected his lunch from the dining hall and took it back to his cell. Lunch time lock down was between 12.46 and 13.59.

During the afternoon Richard can be seen moving around the wing on a number of occasions entering other cells and talking with different prisoners. From 15.41 Richard remained in his cell. Six prisoners can be seen entering and leaving Richard's cell at various times until lockdown.

Tea was served at 16.00 but Richard did not go to lift a meal.

Between tea being served and lock down, two officers can be seen speaking to the occupants of Richard's cell on separate occasions.

At 17.21 all cells were checked and locked down for the night and the night time sanitation system commenced. Richard did not leave his cell anytime after 15.41.

During a meeting with Richard's family on 10 August 2009, the family provided details of a former prisoner who had been on the wing with Richard on the 10 January 2009. They advised that this prisoner had told them that he overheard a prison officer say to Richard, *"Get in your cell, look at the state of you. You'll get the place searched again".*

The person named by Richard's family was approached on a number of occasions and asked to provide a statement. He declined to co-operate with the investigation.

As stated earlier, CCTV shows that for 1hr 40 minutes before the wing was locked down for the night on 10 January 2009, Richard did not come out of his cell. A review of the CCTV does not show Richard talking to an officer prior to him returning to his cell for the last time at 15.41. At 15.08 Richard walked down the wing and out of the camera's sight for less than 10 seconds. It is not possible to say whether a comment, such as that reported was said out of the camera's view at that time. Prior to this, the last time that Richard could have been spoken to by a prison officer, in the presence of another prisoner, would have been when lunch was served at 11.55.

10a. Richard remained in his cell from 15.41 onwards. A number of prisoners visited him in his cell. He did not collect his tea meal served at 16.00 and did not make use of the night time sanitation system after lock down.

11. Suspected Prisoner Overdose

On the night of 10 January 2009, H1 had one officer working in the control room and two officers supervising C and D wings where Richard was located.

At 19.20, a night custody officer came on duty and commenced a body check, in line with Prison Service policy, to ensure that all prisoners were accounted for. During this body check the officer found a prisoner passed out on the floor of his cell. His cell was unlocked immediately. Medical attention was administered and the prisoner was later taken to hospital by ambulance.

CCTV shows this prisoner walking out of the wing at 19.59 unaided by staff or the paramedics, as he was taken to an outside hospital.

During this incident, officers can be seen on CCTV looking through a number of cell flaps on the wing. One of the night custody officers who dealt with the incident explained at interview that, having found the prisoner unconscious, officers *"shouted to other prisoners like 'has he taken anything? What has he taken? What'll help him?' and someone shouted – I forget what he said but it was two types of drugs."*

CCTV shows the night custody officer looking through a number of cell door flaps immediately following the incident. When asked why he did this, he said that he wasn't sure but that he thought it may be that he was looking into the cells of the prisoners who may have spoken up about what drugs the prisoner had taken. One of these cells was Richards.

Richard's family had said that it was their understanding that two prisoners had been taken to outside hospital that day with suspected drug related problems. Enquiries conducted by the investigating team have confirmed that a second prisoner was taken to outside hospital that evening, but that the reason for this was not drugs related.

The Prisoner Ombudsman made an early recommendation on 1 July 2009 in connection with arrangements for notifying prisoners of serious drug related incidents and giving them the opportunity to come forward with information, without repercussion. This is included at the recommendations section of this report on page 22, along with the Prison Services response.

11a. At 19.20 on 10 January 2009 a prisoner in a cell opposite Richard's was found passed out on his cell floor. He was taken to hospital with a suspected drugs overdose.

12. Prisoner Checks on 10 January 2009

Governor's Order number S.7 states, *"on taking up post and on final body check, Night Custody staff must be satisfied that prisoners are clearly seen by seeing their face and observing movement, even if it means waking them."*

This refers to the checks carried out at 19.30 and 07.00.

The order further states, *"Night Custody Officers will ensure a total of five body checks are carried out from midnight until 07.00 in the morning. All body checks will be recorded in the night guard journals."* The checks between 19.30 and 07.00 are purely to confirm that a prisoner is in his cell. There is no requirement to ensure that a sign of life can be seen. In line with Prison Service policy, on 10 January 2009, the night custody officers had not recorded all body checks in the night guard journal. Night custody officers had, however, recorded a general entry to state that body checks were conducted through the night.

Richard's family wanted to know why there weren't increased observations on the wing that night, when a prisoner had been found unconscious. The investigation found that on 10 January 2009, night custody officers did take it upon themselves, to conduct one extra body check at 21.12, because of the earlier incident. This is not, however, a requirement of Prison Service policy where there has been a drug related incident.

The Prisoner Ombudsman made an early recommendation on 1 July 2009 in connection with checks following a serious

incident. This is included at the recommendations section of this report on page 22, along with the Prison Service's response.

CCTV of the extra body check shows a night custody officer checking Richard's cell at 21.12. The officer is seen to look through the cell door flap and kick Richard's cell door. At interview the officer stated that whilst he could not recall anything untoward, the fact that CCTV shows him kicking Richard's cell door would suggest that Richard was already in his bed and, as a result of him kicking the door, Richard must have provided a response before he moved onto the next cell.

12a. As a result of the earlier incident, the night custody officers conducted an extra check, over and above that required by prison rules, at 21.12.

12b. Nothing untoward was noted during this check, but it appears that Richard may have been in his bed at this point because the officer had to kick his door, apparently to elicit a response.

12c. It is likely that Richard did respond at 21.12 because the officer took no further action.

Both night custody officers who were interviewed stated that they were not familiar with individual prisoners on the wings because the main interaction staff have with prisoners is on the day shift. It is for this reason that they stated that they would not really know if it was unusual for Richard to be in his bed at this time. They said that due to the number of prisoners on the wings, they do not have knowledge of their individual routines.

Even before the 21.12 check, both night custody officers can be seen on CCTV at different times, looking in at a few cells. One of these cells was Richards. Both night custody officers were asked during interview the reason for this and whether or not they had discussed with one another any concerns about the occupants of the cells. The officers could not recall anything specific, but both said that it was likely that the occupants in the cells had been asking about the earlier incident and whether the prisoner concerned was okay. They stated that there would have been no other reason for them to have been looking through the cell door flaps.

Following the check at 21.12, CCTV shows both night custody officers carrying out night sanitation unlocks until the next scheduled check at midnight. There is no further checking of any cell during this period.

The night custody officer conducting the midnight check stated that, in line with Prison Service policy, this check was purely to ensure that there was a person in each cell. There was no policy requirement to check for a sign of life. The officer said that he could not recall anything specific about Richard during this check.

12d. There was nothing untoward noted at the check conducted at midnight. This check was to check that someone was in each cell. It did not require evidence of a sign of life.

13. Initial Response on Finding Richard

After the midnight check, the next scheduled body check was at approximately 02.00. As with the check at midnight the purpose of this was to check that there was a person in the cell. There was no requirement to ensure that there were signs of life.

Richard's family were concerned that at the 02.00 check, Richard may have responded in a manner which was in fact him having a fit.

CCTV shows that a different night custody officer carried out this check from the one who carried out the midnight check. At 02.11 the officer can be seen kicking Richard's cell door for approximately one minute and then walking back down the landing.

In a statement the night custody officer said:

"I looked through the observation port, I could not see any movement, the covers were up over Richard Gilmore on the bed and the only part visible of him was the left temple area and left eyebrow. His main light had been left on and there was liquid spilled on the floor. The combination of all these things arose my suspicion that something wasn't right. I kicked the door and called his name. I opened the door to the pin, which when opened, opens the door about an inch and a half. I called his name a couple of times and got no response. At approximately 02.12 I left the wing to alert the emergency control room via our controller."

From the account of the officer who found Richard it is clear that Richard was not having a fit, but was lying unresponsive when checked at 02.11.

The officer then went to the H1 control room located at the entrance of the building and asked the controller to alert the Emergency Control Room of his concerns. The officer did not treat this as an emergency unlock situation.

In an emergency unlock, a cell door is opened immediately with only two officers present. In any other situation, there is a requirement to have three officers present. As there were only two officers on H1 C and D wing on 10 January 2009, this meant calling for assistance. At interview, the night custody officer was asked why, as he was concerned about Richard, this wasn't treated as a situation requiring an emergency unlock. He said, *"I honestly didn't think... Prisoners in the past have, in the morning like, when you're trying to get them up, kicking the door they'll lie as still as possible. And make you kick the door more and more"*

Governors Order number S.8 "Night Custody Emergency Unlock" states that;

"In life-threatening situations, staff will immediately adopt the following procedures:-

1. *Activate the nearest alarm*
2. *Inform ECR, giving brief details*
3. *Two staff to be present at any emergency unlock.*
4. *Cell key to remain in possession of unlocking staff.*

5. *The third member of staff will remain in the Block Control Room and observe the unlock on the Wing camera.*

NB: In life-threatening situations, staff must act with the following in mind: CONTROL, SECURITY and STAFF SAFETY."

The requirement for control, security and staff safety must always be considered because there have been instances of prisoners constructing an apparent life threatening situation and then attacking staff who respond in an attempt to assist them.

With reference to the above order, the night custody officer who found Richard unresponsive, said that he would class a life threatening situation as seeing someone hanging, the sight of blood or in the obvious case, as with the prisoner earlier that night, a prisoner collapsed on the floor.

The night custody officer said that what raised his suspicion on this occasion was that Richard's light was still on, which was unusual for that time of night. At interview, the other night custody officer who checked Richard's cell at midnight couldn't recall if the light was on at that time or not. Both night custody officers said that at the time of the 02.11 check, and afterwards when they checked again, they couldn't see Richard's face due to the duvet being up over him. Other than the fact that a bottle of water had spilled over onto the floor, there was nothing else untoward to suggest that Richard needed assistance. The night custody officers and the controller did not appear to take account of the fact that another prisoner had been taken to hospital earlier in the evening when deciding whether or not the situation required an emergency response.

Both night custody officers stated that they awaited the arrival of the senior officer before opening Richard's cell, because in their view this was an unresponsive prisoner, rather than an emergency situation. There were no other members of staff in H1 who could have assisted, in order for a non emergency unlock to be affected without the senior officer. For security reasons, the control room officer is never permitted to leave the control room for the purpose of assisting with any unlock.

13a. When Richard was checked at 02.11 his blanket was pulled up over his face, his light was on and there was liquid on his floor.

13b. The officer who found Richard was concerned that something was not right, but did not believe that the situation was life threatening and required an emergency unlock.

13c. The officer alerted the Emergency Control Room of his concerns, via the controller in H1.

14. Actions of the Controller

An entry in the House Control Room Journal at 02.12 records, *"H2660 Gilmore does not respond during head count. ECR informed."*

At interview the control room officer described his role as, *"the nerve centre, the hub of the block"* and explained that every unlock request has to go through the controller. This includes medical, non emergency and emergency unlock requests. The control room officer then has to liaise with the Emergency Control Room (ECR), in order to request further staff for their assistance and inform them of the situation.

At interview the control room officer was asked to recall how the alarm was raised when the night custody officer was concerned by what he observed when checking Richard at 02.11. In his response, the control room officer stated, *"The officer came up to the hatch at the control room.....he told me that he couldn't get a response from Gilmore. And at that point, as far as my memory goes, I asked him to go back down again and kick the door. That's when I phoned the ECR to let them know."* The control room officer further stated that when he called the ECR, from what he could recall, he told them, *"that we have a prisoner who is unresponsive"* and requested the senior officer attend.

14a. The controller notified the Emergency Control Room as soon as he was informed that Richard was not responding to staff.

15. Actions of the Officers While Awaiting the Arrival of the Senior Officer

At 02.16 the night custody officer who raised the alarm can be seen on CCTV going back to Richards's cell and kicking it a few times, before checking all of the other cells and leaving the wing.

CCTV shows that at 02.20 both night custody officers came back to Richards's cell. The night custody officer who had not carried out the check at 02.11 can be seen looking through the cell door flap and kicking the door again. After only a short while, both officers can be seen walking back down the landing.

At interview the second night custody officer, was asked how he became aware that his colleague was concerned that Richard was unresponsive and what his reaction was. The night custody officer said that *"He (the officer who found Richard) said he couldn't get a response from Gilmore and would I come down and give him a hand to see if I could get one....I went down and kicked the door. We opened it so that it was on the pin[21], and shouted in and there was still no response."*

This officer was asked whether there was a sense of urgency, when he was informed that Richard was unresponsive. In his response he stated, *"He (the night custody officer who found Richard) wasn't panicking or anything but I think he was slightly worried, but it's not unusual to not get a response."*

The second night custody officer was asked why he didn't go to Richard's cell straight away when asked. It appears to be the case that the officer did not believe that he was dealing with an emergency. He also knew that no unlock would take place until the senior officer arrived.

[21] Opening of cell doors to the "pin" – Officers can open the cell doors approximately one inch without having to gain permission to fully open the cell door.

15a. Further attempts were made to get a response from Richard while the night custody officers on H1 waited for the arrival of the senior officer in order that a medical unlock could take place.

16. Arrival of the Senior Officer and Nurse Officer

CCTV shows that it took 11 minutes from Richard being found unresponsive by the night custody officer on the wing to the senior officer and nurse officer arriving at Richard's cell at 02.22. The cell door was opened in less than a minute and the senior officer and nurse officer entered immediately.

The senior officer and nurse officer were asked to explain why there was a delay of 11 minutes from Richard being found unresponsive to them arriving at his cell. They both said that when they were notified of this incident they were in the old hospital building. The nurse officer was using the computer facilities when the phone call came through from the Emergency Control Room to notify them that Richard was unresponsive. The senior officer had previously notified the Emergency Control Room of his location and he said that while he was doing work on another computer, the phone rang and the nurse officer answered it. The nurse officer advised him that *"there's a medical unlock, there's an unresponsive prisoner in H1."*

The senior officer further explained that as soon as the nurse officer came off the phone, she immediately started to search for Richard's medical information on the computer system and gather up what she required from the office. While this was happening, the senior officer retrieved the keys to the medical van in readiness to drive from the old hospital to H1. The distance from the old hospital to H1 is approximately 700 yards. The senior officer explained that he didn't use his own van which was parked outside the hospital because it wasn't facing in the correct direction and he thought that using the medical van would avoid unnecessary delay.

The senior officer stated at interview that, *"The main waiting I would have done would have been on the nurse officer because she had to check all Richard's information and then start to gather stuff..."* The senior officer further explained that whilst waiting in the van he radioed through to the Emergency Control Room to ensure that all the gates were opened to prevent any further delay in them getting to H1.

Governor's order number L.8 "Action to be taken by Healthcare centre staff on receipt of information of a suicide, attempted suicide or other emergency incident" states, *"Acting on information received, a member from the Healthcare Centre will proceed without delay to the incident."* In this instance staff had been notified of an "unresponsive prisoner".

The nurse officer stated at interview that, following the call, she "*immediately went onto EMIS, which is our patient notes on the computer to see if he (Richard) had any history... whether he was... epileptic or he was diabetic... any other health problems, so that I knew what ... I had a sort of background as to where, you know, what problems he has before I go to him, or any related drug problems."*

At interview the nurse officer was asked whether it would be normal practice for her, or any nurse to access medical information before attending a medical unlock request. In her response she said, *"I think its better because then you know, if you had a history, you know exactly what you're going too really. If you don't know their background, whether there's any heart problems, whether they're epileptic, whether they're diabetic, it just makes the diagnosis easier whenever you've got to them."*

During a night shift, there is only one nurse officer on duty for the entire prison. Due to patient confidentiality only medical

staff can access the EMIS system. There was, therefore, no one else available to access and provide the nurse officer with any information from EMIS.

The nurse officer stated that the main reasons for the delay in getting to Richard would have been due to her looking up Richard's medical information on the computer system and the distance from the old hospital to H1.

In his Clinical Review Report, Dr Peter Saul stated, *"The nurse officer's explanation that she wanted to get further information about Mr Gilmore from the computer system was reasonable. Looking at her statement and the interview it seems that she was given the impression that Mr Gilmore was unresponsive rather than the subject of a cardio-pulmonary arrest. I am familiar with the EMIS system and it takes just a minute or so to launch the programme and gather any key clinical details. Given the information she had been given her actions were quite reasonable."*

16a. The senior officer and nurse officer were in the old hospital when the Emergency Control Room called to inform them that Richard was not responding to staff.

16b. Before proceeding to H1, the nurse officer accessed Richard's medical information in case he had a medical history that she should be aware of and in order to, therefore enable her to, administer appropriate treatment quickly. The nurse officer stated the distance from the old hospital to H1 also added to the delay in getting to Richard.

16c. The senior officer and nurse officer arrived at Richard's cell 11 minutes after he had been found unresponsive by the night custody officer.

17. Actions after Richard's Cell was opened

At 02.23 Richards's cell was opened and the senior officer and nurse officer entered his cell. The senior officer stated:

"I was shouting at the prisoner to try and get a response. I reached for the duvet and pulled it back to see his face. His face was purple/blue and, at that, the medical officer was coming around to my right and was shouting and shaking him trying to rouse him. I pulled the duvet back towards the end of the bed under the TV.... He was lying on his left with hands curled, his legs up to his chest and his right leg suspended in the air....The nurse officer was working on him and someone went for a defibrillator and oxygen....the defibrillator was going through its programme...I heard 'continue CPR, call an ambulance'..."

The Clinical Reviewer, Dr Saul, said that the defibrillator response, encouraging the continuation of CPR, was likely to be explained by the fact that Richard's heart had stopped, which is not treatable by shocking.

In her statement the nurse officer stated;

"On examination he (Richard) was lying in the foetal position and he appeared to have had a seizure as his teeth were clenched and he was unresponsive. I immediately requested an emergency ambulance and doctor... I asked the two officers to get my oxygen and defibrillator from the medical room. I then shook the prisoner to try and get a response at this time. His pupils were also unresponsive to light. I immediately checked for a pulse and placed the pulse oximeter on his finger but there was no pulse found. I was unable to insert an airway as his teeth were

clenched and fixed so I immediately commenced CPR and oxygen therapy with the assistance of one of the officers. I also carried out suction as I noticed he had been bleeding from his nasal passages and appeared to have a lot of brown fluid in his mouth and nasal area. I continued CPR until paramedics arrived at 02.45."

On manoeuvring Richard to a position which enabled CPR to be conducted, the night custody officer who assisted the nurse officer said at interview that he found a yellow plastic Kinder Egg container lying on the bed behind Richard. Within the container were some tablets wrapped in bubble wrap. This was handed to the senior officer, who in turn handed it to the police officers who later attended.

Despite their efforts staff were unable to resuscitate Richard.

When the nurse officer was asked if she could indicate how long Richard was likely to have been in this condition she advised *"Richard was not cold to touch."* She further stated that when she went back to see Richard with the PSNI photographer she "*noticed a big difference in his body colour. He was (initially) red, quite red in the face and slightly blue. Later on, at five o'clock in the morning, he was very mottled. His body was mottled."*

In his report the clinical reviewer, Dr Peter Saul, said: *"There is discussion in the statements about the fact that he was stiff and had clenched teeth. A seizure has been postulated but really this is just speculation".*

Dr Saul concluded that:

"Mr Gilmore's treatment had been appropriate. In this case earlier entry to the cell is unlikely to have made any difference but might in other circumstances. It is impossible to determine the time of death other than to say that Mr Gilmore is likely to have been dead at the time of discovery."

CCTV observations show that officers actions are consistent with the accounts provided by all four members of staff who dealt with this incident.

17a. When entry was gained to Richard's cell, continued attempts were made to resuscitate him. Despite their efforts it was not possible to resuscitate him.

17b. A yellow plastic Kinder Egg container with tablets inside was found on Richard's bed.

17c. The Independent Clinical Reviewer concluded that it is unlikely that earlier entry to Richard's cell would have changed the outcome, but that it might in other circumstances.

18. Concerns that Richard may have been sick

Richard's family had been informed by the undertaker that Richard had purging marks on his face consistent with him being sick. The family wanted to know if Richard had been sick and if so, why no one came to his assistance. The prison officers and nurse who attended Richard on the night of 10/11 January 2009 said that they saw no evidence that Richard had been sick in his cell. The nurse officer did advise that there was brown fluid coming from Richard's nose which could have been vomit and that there was some brown staining on his pillow which could have been caused by the same fluid. The nurse officer also advised that she caused some staining on Richard's bed clothes when carrying out chest compressions, as the brown fluid was being pushed out of his nose and mouth.

The information provided at interview and the photos taken by the police photographer, do not suggest that Richard had been wrenching and/or vomiting. There was, however, evidence of the brown staining as described by the nurse officer.

18a. Richard's family were concerned that he may have been sick and had not received assistance.

18b. Brown fluid had excreted from Richard's nose and his pillow was stained with the fluid.

18c. There was no evidence that Richard had been sick anywhere else or that he was retching or vomiting.

19. Paramedic Attendance and Subsequent Action

CCTV shows that paramedics entered Richard's cell at 02.47. One of the paramedics moved out of the cell at 02.51 and the second moved out at 02.55. At interview the nurse officer advised that, once the paramedics arrived, they attached leads to Richard and hooked these up to their equipment. A heart trace was carried out, but no response was obtained and no further medical assistance was given to Richard.

While the paramedics were in Richard's cell, the senior officer instructed the two night custody officers to carry out a full check of all of the prisoners on H1 C and D. The officers were required to ensure that a response was obtained from each prisoner. Both night custody officers can be seen carrying out this action on CCTV.

The paramedics left at 03.13.

At 02.41, Magilligan's chief medical officer was contacted and was informed of the situation. The chief medical officer advised the Emergency Control Room that he was out of the country and to contact the police forensic medical officer. In normal circumstances the chief medical officer would have attended to confirm and pronounce life extinct. As a result, at 02.55 the Police Service of Northern Ireland's duty forensic medical officer was requested to attend. She attended at 05.08, and due to this delay Richard's time of death was recorded as 05.12.

19a. Paramedics were unable to obtain a trace of Richard's heart and left H1 at 03.13.

19b. Delays in getting a chief medical officer to the Prison meant that Richard's time of death was recorded as 05.12.

20. In-Cell Call Alarms

Richard's family were concerned to know whether Richard tried to raise the alarm for assistance and if he did so, did he get the necessary attention.

Within each cell there is a buzzer which prisoners can use when they require any type of assistance during lock down, including a request to use the ablutions area.

On the evening of 10 January 2009 the control journal notes that at;

21.55 Buzzers on cell call alarm panel does not work – ECR informed.
22.50 Trades arrive at block
23.11 Trades leave block – Buzzer fixed.

At interview, the control room officer said that he noticed that the buzzer to alert him when a cell alarm is pressed was not working. The lights, which also go on to notify him that a cell call alarm has been pressed, were still working. The control room officer stated that he reported the fault to the Emergency Control Room and the problem was then rectified. He confirmed that, because the lights were still operating, he was still aware when a cell call alarm had been pushed.

As well as the control room officer being aware of any activated cell call alarms, there is a light which illuminates outside the cell. This means that the officers who are on the wings can also observe when an alarm has been activated.

At interview the night custody officers on duty on the night of 10 January 2009 stated that they could not recall Richard using his cell call alarm button to be let out for ablutions or any other reason.

CCTV does not show Richard's cell alarm light illuminating.

20a. There is no evidence that Richard used his in cell call alarm on the night of 10 January 2009.

SECTION 5: INCIDENT MANAGEMENT AFTER RICHARD'S DEATH

21. Action to be taken following a Death in Custody

The documents 'Contingency Plans Forty Four and Forty Five – Death of a Prisoner' clearly details the roles and responsibilities of all members of staff upon notification of a possible death.

Using the contingency plans, the Emergency Control Room which controls and records all movements around the prison, immediately notified the appropriate personnel of the time, and preliminary assessment of the cause of death. This included, amongst others, the Police, the Coroner's Service and the Prisoner Ombudsman. The Emergency Control Room incident log records this action.

Further to this, the Duty Governor contacted the prison chaplain who attended the prison at 05.20 and administered the Last Rites at approximately 06.00. The prison chaplain then made contact with Richard's local Parish Priest who contacted Richard's family. The Chaplain advised that he passed on the condolences of the chaplains and staff at Magilligan.

21a. The correct procedures were applied when notifying the appropriate personnel of Richard's death.

22. Preservation of Evidence

When any prisoner dies it is important that the Prison Service takes all necessary steps to ensure the preservation of a scene and evidence. Governors Order 3-12 sets out what procedures should be followed in the event of such an emergency.

From the examination of events following the alarm being raised and consultation with the PSNI, it is clear that prison and healthcare staff carried out their duties in line with Prison Service policy and procedures.

22a. Prison Service policy and procedures for managing the scene of an incident were adhered to.

23. De-briefs

Hot De-brief

The Prison Service's Revised Self Harm and Suicide Prevention Policy issued in September 2006, states:

"A Hot De-Brief meeting is vital following the death of a prisoner as it enables all who took part to comment, while it is fresh in their minds, in respect of what went right or what could have been done better. Hot De-Brief meetings make a positive contribution to the implementation of better practice locally, and sometimes, across the Prison Service. It also gives staff the opportunity to discuss their feelings and reactions and calm down or seek help before going home."

Page 20 of the Addendum to the September 2006 Self Harm and Suicide Prevention Policy issued in January 2009 now states that *"a brief note should be taken of those attending, and matters raised."* This amendment resulted from a recommendation made by the Prisoner Ombudsman, following an earlier death in custody investigation.

The Duty Governor at Magilligan Prison did not carry out a hot de-brief meeting with all who took part, but instead spoke to those involved on an individual basis. In the record of the hot de-brief, the Duty Governor recorded;

"I carried out a hot, informal, debrief with all of the staff who attended…I was aware that the staff were going to be interviewed by both police and the Ombudsman's investigator before they would be allowed to leave the establishment. On this basis I made the decision not to sit down formally with all of the

staff, but chose to talk to them individually….I continually praised the staff, reassuring them and showing support."

23a. An informal hot de-brief was conducted by the Duty Governor.

Cold De-brief

Section 6.11 of the Self Harm and Suicide Prevention Policy requires that *"a more comprehensive [cold] de-brief should take place within 14 days*".

The purpose of this meeting is to allow all those who involved in the incident, as well as key stakeholders, to review the circumstances of the incident and identify any learning points.

A cold de-brief took place on 26 January 2009, 15 days after the incident and minutes were produced. Two of the four officers who responded to this incident were not present at the meeting. The senior officer who attended the incident stated that little notice was given of when the cold de-brief was going to take place and little consideration was given to the timing of the de-brief, given that the two officers who couldn't attend work night shifts.

23b. In line with Prison Service policy, a cold de-brief should take place within 14 days of the incident taking place. The cold de-brief for this incident took place after 15 days.

23c. All members of staff involved in the incident should be given the opportunity to attend the cold de-brief. Two officers were unable to attend the de-brief because of the time it took place.

24. Immediate Action Plan Produced by Magilligan Prison

Following Richard's death the Governor requested a review of all actions on the night, in order to highlight any learning points and raise the awareness of drugs misuse. The following actions were drawn up as a result of the review:

1. *A notice to go to all prisoners re dangers of drug misuse and offer of amnesty to surrender any illicit drugs to prison authorities.*

2. *A3 sized posters to be devised and issued around all residential prisoner notice boards re dangers of illicit drugs.*

3. *A5 sized flyers to be devised and issued to all visitors regarding the dangers of all illicit drugs.*

4. *On the job training to be devised and delivered to Officers regarding the handling of serious incidents.*

5. *Contingency plans in ECR for all types of serious incidents to be reviewed and produced in checklist form.*

6. *Intelligence led searching to be carried out in residential areas in light of Richard Gilmore death in custody.*

7. *Consideration should be given to the issuing of Governor's Commendations to those staff that performed in an exemplary manner in dealing with the overall incident.*

8. A cold debrief to be conducted by the Deputy Governor to review the events surrounding the death in custody. It will involve all of the staff involved in managing the incident and will examine what went well and what lessons can be learned, if any. This debrief will be minuted.

24a. Following Richard's death, an immediate action plan was drawn up by the Governing Governor of Magilligan Prison.

SECTION 6: AUTOPSY AND TOXICOLOGY REPORT

25. Autopsy and Toxicology Report

On 12 January 2009, an autopsy was carried out to determine Richard's cause of death. Blood and urine samples along with other oral swabs were taken to determine any presence of alcohol and drugs.

At the autopsy there was no obvious sign of the cause of Richard's death but the subsequent toxicological analysis of the samples revealed the presence of a number of drugs.

The toxicology report concludes that:

- The blood, urine and stomach contents samples from Mr Gilmore contained evidence of the prior use of buprenorphine, codeine (and possibly morphine), diazepam, cocaine and paracetamol.

- The presence of codeine in the stomach contents indicates the recent consumption of codeine (although as explained above it cannot be ruled out that the direct use of morphine was used at some point prior to his death).

- The presence of diazepam in the stomach contents and in the nasal swab indicates the recent intake of diazepam by ingestion and snorting.

- The concentrations of buprenorphine, diazepam, codeine and its metabolite (morphine) detected in the blood of Mr Gilmore lay within the range of values found following normal

therapeutic use of these drugs and are capable of causing pharmacological effects. It should be noted that in a case of a slow demise, the concentration of these drugs would be expected to have been higher at some time earlier prior to his death.

- The effects of buprenorphine would most likely have been enhanced by the presence of diazepam, codeine and morphine. The combined central nervous system depressant effects of all these drugs at the concentrations indicated could very well account for the death of Mr Gilmore.

- A small amount of cocaine was detected in the nasal swab. This result suggests that this drug may not have been snorted recently.

- The concentration of cocaine and benzoylecgonine (a metabolite of cocaine) detected in the blood suggests the non-recent use of cocaine. However, it would be expected that the concentration of cocaine in the blood of Mr Gilmore to be significantly higher prior to his death. The possible side effects of cocaine are described above.

- A therapeutic concentration of paracetamol was detected in the blood of Mr Gilmore. As explained previously, paracetamol would likely have contributed little to the overall pharmacological picture.

- A very small concentration of alcohol was found in the blood sample of Mr Gilmore. As explained above, it is most likely that the presence of alcohol was the result of alcohol post-

mortem production. No further significance is attributed to the presence of this compound.

- The blood and urine samples supplied from Mr Gilmore were examined for drugs of abuse, benzodiazepines, prescription and non-prescription medicines. All analyses gave negative results (with the exception of those drugs listed above). These negative findings rule out the involvement of these particular substances at the time of death.

The scientific officer concluded that the *"CNS depressant effects of these drugs at the concentrations indicated could very well account for the death of Mr Gilmore."*

Richard's cause of death is recorded as "Mixed Drug Toxicity".

The only prescribed medicine Richard was taking at the time of his death was co-codamol.

SECTION 7: STAFF TRAINING

26. Training

First Aid Training

On the night of 10/11 January 2009, prison officers worked with the nurse officer to assist Richard.

A review of the first aid training the officers had received prior to this incident identified that:

- The senior officer had attended a four day first aid course in February 2006
- One of the night custody officers had attended a half day 'Buddy Care[22]' course in November 2004; and
- The other night custody officer had attended a half day 'Buddy Care' course in November 2004 and a four day first aid course in February 2006.

The Training Manager at Magilligan stated, "*first aid at work (FAAW) is not mandatory. Under the Health and Safety at Work (NI) Order we must provide a specified number of staff trained in First Aid at Work per number of employees (1 for 25). We currently have 478 staff (requiring 20 FAAW trained staff) and have 72 trained for FAAW.*"

Those members of staff who attend the training are trained in accordance with the Health and Safety at Work Order, to provide First Aid to other members of staff only, although in

[22] Buddy Care Course – A half day training course provided to the Night Custody Officers during their initial training when they join the Prison Service. The course covers basic life support techniques.

practice most staff will provide emergency first aid for prisoners when the need arises.

Since September 2009, changes have been introduced to the Control & Restraint Basic Training Course which all staff are required to attend once a year. An element of the original training plan has been removed and replaced with CPR and auto-defibrillator training which can be administered to staff and prisoners, as required.

Training for Serious Incidents

As noted earlier, an action plan was prepared as a result of the review requested by the Governor. Point four of the plan states:

"On the job training to be devised and delivered to Officers regarding the handling of serious incidents."

Following Richard's death and other emergency situations and as a result of recommendations from the Criminal Justice Inspectorate, Her Majesty's Inspectorate of Prisons and the Prisoner Ombudsman, the training team in Magilligan developed a Night Guard specific 'Procedures During Lock-Up' (PDL) training course. This course delivers practise scenarios which are enacted to practise responses to emergencies requiring an urgent unlock.

Positive feedback was received by staff who took part in this course and recommendations were put forward by participants to the Governor for his consideration.

The following recommendations were made:

1. All remaining night custody officers and their supervisors should complete the PDL course.

2. The PDL course should be amended for all other establishments and delivered locally for all night custody staff and their supervisors.

3. Consideration should be given to the provision of PDL training for residential day staff.

4. Outstanding orders and instructions for emergency unlock procedures should be provided to Sperrin, Alpha and Foyleview accommodations.

5. Night Custody Officers should be encouraged to carry out searches during the lockup period.

26a. Since September 2009, CPR and auto-defibrillator training has been introduced in the compulsory Control and Restraint training for the use of prisoners and staff.

26b. Scenario based training has been delivered to night custody officers to ensure an efficient and effective response in any situation requiring an emergency unlock.

SECTION 8: THE MANAGEMENT OF DRUGS AT MAGILLIGAN PRISON

Background

One of the first questions asked by Richard's mother was why her son was not safe in prison from the misuse of drugs.

27. Northern Ireland Prison Service Policy on Alcohol and Substance Misuse

The management of the supply and use of drugs presents a major challenge to prisons everywhere. The Governing Governor at Magilligan Prison is committed to trying to keep Magilligan Prison drugs free. At the same time, wherever possible, he does not want to introduce measures which disadvantage or appear to punish prisoners and visitors who never abuse drugs. This balance can, at times, be difficult to achieve.

In July 2006, the Northern Ireland Prison Service published its policy on alcohol and substance misuse, which endorsed the following principles:

(a) *"Zero tolerance will apply to all drug (illicit and prescription) and alcohol misuse in prison;*

(b) *Prisoners will be continually encouraged, and challenged, to assume responsibility for their own substance misuse behaviour;*

(c) *Prisoners experiencing drug and alcohol dependence, or suffering health problems as a result, will be offered*

therapeutic interventions equivalent to those provided in the community but appropriate to a prison environment;

(d) With the assistance of Resettlement Teams, Health and Personal Social Services, Voluntary Drugs Agencies and the Probation Board of Northern Ireland, discharged prisoners should be offered on-going rehabilitation and support on their return to the community and be encouraged to maintain their contact with community addiction services."

In line with this overall policy, "*each Governing Governor is required to develop a local action plan, which sets out how the specific requirements of the policy on Alcohol and Substance Misuse will be implemented."*

Magilligan Prison does not have a local action plan but, as required by the Drug and Alcohol misuse policy, Magilligan Prison has implemented a drug steering group which meets bi-monthly and is attended by staff from the Offender Management Unit, Safer Custody Group, Resettlement Board, Probation Team, Healthcare Team, Dog Unit and the Independent Monitoring Board, to discuss and action issues surrounding the fundamental principles of the service wide Drug and Alcohol Misuse Policy.

Magilligan Prison identified the following possible interventions for reducing the supply of drugs into the prison:

- All persons entering the establishment may be rubdown searched[23].

[23] Rubdown Search – Clothes remain on. The searching officer systematically sweeps over areas of the body to locate prohibited articles or substances.

- Restriction on prisoners' parcels to reduce drug smuggling opportunities.
- Some telephone calls to be monitored to provide drug related intelligence.
- A pre-booked visiting system to ensure that seating allocation will ensure CCTV coverage in all visits areas.
- Passive drugs dogs[24] to be regularly deployed.
- Voluntary drug testing.
- Procedures for collating, evaluating and disseminating intelligence on drug matters.
- Intelligence led searching.
- Drug free wings for those prisoners who agree to be drug free and cooperate with random drugs testing.

27a. The Prison Service policy on Drug and Alcohol Misuse states each establishment is required to develop a local action plan setting out how this policy will be implemented.

27b. Magilligan Prison does not have a local action plan as required. Magilligan Prison has implemented a drug steering group which meets bi-monthly to discuss and action issues surrounding the fundamental principles of this policy.

[24] Passive Drugs Dog – Visitors are required to stand and allow a passive drugs dog and its handler to move past them in order for the dog to 'indicate' to it's handlers of the possible presence or trace of a banned substance.

28. Monitoring of drug related information in Magilligan Prison

A comprehensive monthly monitoring system is in place at Magilligan Prison to provide a trend analysis of drug related data such as drug finds, drug related adjudications, prisoners committed or remanded on drug related charges, voluntary drug testing, deployments of the passive drugs dogs and those prisoners or visitors who are restricted to closed visits because of being suspected of possessing drugs.

This information is used to provide statistics and analysis of the information for the Northern Ireland Prison Service Senior Management Team and also to inform local decision makers with regards to Security and Search objectives. It is also worth noting that this information is provided to the Police Service of Northern Ireland and, with the exception of sensitive information, is also published in composite form on the Prison Service website.

In November 2008, two months before Richard's death, drugs were found in eight locations in Magilligan prison. Drugs were also found on nine prisoners and on one visitor. The quantity and types of drugs found were:

Substance Found	Quantity / Weight
Tablets	271
Cannabis	75.2grams
White Powder	2.1grams
Green Substance	3.2grams
Brown Substance	67.6grams
Nandropen	1 x 10ml ampule

In December 2008, drugs were found on three prisoners. The quantity and types of drugs found were:

Substance	Quantity / Weight
Tablet	1
Cannabis	0.2grams
LSD	3 tablets

In January 2009, drugs were found on 11 prisoners as well as at other undisclosed areas (due to the information being sensitive). The quantity and types of drugs found were:

Substance	Quantity /Weight
Tablets	Approx. 300
Liquid Aredindizepam	85
Heroin	1.2grams
Cannabis	1.3grams
Dark Brown Substance	Not recorded
Buprenorphine Tablets	Not recorded

In February 2009, drugs were found on five prisoners and in four locations. The quantity and types of drugs found were:

Substance	Quantity / Weight
Tablets	239
Cannabis	4.9grams
Brown Substance	23.5grams
Liquid	1 bottle, 2 phials
Leafy Substance	Not recorded

This detailed information is not sent to the Offender Management Unit or the drugs steering group. However, at

meetings of the drug steering group a member of the security team briefs the group on drug finds and trends.

28a. Magilligan Prison carries out comprehensive monitoring of drug related data. The information informs search and security objectives.

29. Drug Free Wings

Richard's family asked why at the time of his death, he was on a "drugs wing".

Whilst all prisoners are expected to be drug free, Magilligan Prison has dedicated drug free accommodation, where prisoners are required to agree to random drug testing as a condition of being resident in the accommodation. Drug free accommodation includes a newer, more modern facility. It is hoped that the incentive of higher quality accommodation will encourage prisoners not to use illicit drugs. Prisoners can request to be moved to drug free accommodation, providing they agree to the terms placed upon them. They have to also pass a drugs test prior to relocation.

On 12 September 2008, Richard passed a voluntary drugs test and was subsequently moved to a wing designated as drug free on 16 September 2008. This was H1 A and B wing. On 9 October 2008, whilst Richard was in H1 A and B wing, he met the requirements of promotion from Standard to Enhanced regime, on the condition he passed another voluntary drug test. On 10 October 2008, Richard took this voluntary drug test but subsequently failed it due to the presence of buprenorphine, a non prescribed prescription drug. As a result, on 30 October 2008, when the failed drug test notification was received, Richard was demoted back to the Standard Regime and was removed from the drug free wing of H1 A and B to the standard accommodation in H1 C and D.

During the course of the investigation it appeared to be the case that there is a general acceptance that drug free wings are not, in fact, drugs free.

The Prisoner Ombudsman made early recommendations on 1 July 2009 in connection with the management of drugs free wings. These are included at the recommendations section of this report on page 22, along with the Prison Service's response.

The Prisoner Ombudsman also informed the Prison Service that prisoners, removed from drugs free accommodation for failing a drugs test, should be given every support to get back to the drugs free accommodation as soon as possible.

Drugs are not permitted in any area of Magilligan Prison but H1 C and D wing, where Richard died, was not one of the dedicated drugs free wings where the occupants are required to co-operate with random voluntary drug tests. At the time of Richard's death, only Enhanced level prisoners located on H1 C and D would have been subjected to random voluntary drug tests.

29a. Drugs are not permitted in any area of Magilligan Prison.

29b. The Prison has dedicated drug free accommodation which prisoners can request to be moved to. The conditions of residing in this type of location are that occupants must be drug free and agree to co-operate with random voluntary drug testing.

29c. Between 16 September 2008 and 30 October 2008, Richard was located in H1 A and B wing, which at the time was a dedicated drug free wing.

29d. Richard was moved off H1 A and B wing on 30 October 2008 having failed a voluntary drug test.

30. Voluntary Drug Testing Arrangements

Voluntary Drug Test Unit

All drug tests are administered in the voluntary drug testing Unit (VDT Unit). The primary function of the VDT Unit at Magilligan Prison is to administer drug tests to prisoners to ensure that they are drug free.

It was established that the unit is staffed five days a week and sits on a 'diminishing task line.' This is a list of work areas that staff will be taken from if there are staff shortages. Where staff shortages occur, the unit may not be open five days a week.

Testing Methodology

At the time of Richard's death, drug testing was carried out using a urine sample provided by the prisoner. Results can be affected by a number of factors. These include:

- prisoners drinking excess fluids prior to the test, which will dilute the sample to such an extent the result cannot be used.
- samples being provided that are not the prisoner's own.
- samples being provided that were collected by the prisoner at an earlier date, when they knew there would be no trace of prohibited substances.

Analysis of Tests

Until February 2010 the service level agreement between the Northern Ireland Prison Service and the drug testing facility only

allowed for the samples taken to be sent for testing twice a week. Likewise the results of the tests were only received twice a week. This meant that it may take several days to identify a positive result.

The Prisoner Ombudsman made an early recommendation on 1 July 2009 about replacing the testing of urine with a swab test. This is included at the recommendations section of this report on page 22, along with the Prison Service's response.

The Prison Service has piloted 'Swab Testing' as a more simple and effective method of obtaining a drug test sample by swabbing the inside of a person's mouth. Swab testing is easier to administer, provides faster results and does not require a specialist VDT Unit. It also eliminates the problems identified in connection with the dilution of samples and the provision of non related and current samples.

In October 2009, the Prison Service, in their response to this recommendation, stated that they anticipated Swab (saliva) Testing would be introduced by the end of 2009. Swab testing has not yet been introduced but information has been sought on the revised plans for its implementation.

Frequency of Tests

The Progressive Regimes and Earned Privileges scheme (PREPS) allows prisoners to work towards increased privileges and incentives according to the three different regime levels of Basic, Standard and Enhanced.

Northern Ireland Prison Service Corporate PREPS policy states:

"Prisoners on all three regime levels will be subject to voluntary drugs testing and at regime level progression testing stage."

This means that all prisoners should be subject to random voluntary drug testing regardless of whether they are on the Basic, Standard or Enhanced level within the PREPS system. Any failure, whether from voluntary testing or progression testing will be taken into consideration when considering a regime level reduction.

Enquiries into drug testing arrangements at Magilligan, at the time of Richard's death, established that the Prison was working to a local PREPS policy in respect of voluntary drug testing. This policy stated that only prisoners eligible for promotion to Enhanced status had to successfully pass a voluntary drug test and only enhanced prisoners had to agree to random testing thereafter.

From analysis of voluntary drug test records and staff interviews, it was evident that those prisoners on Basic or Standard regimes were being tested in the following circumstances only:

1. At the point where a prisoner was ready to progress to Enhanced level.

2. When going out and returning from temporary leave.

3. As part of the requirement to qualify for residence in a drug free wing.

Prisoners at Magilligan Prison on the Standard or Basic regime were not, therefore, being tested on a random basis in accordance with the corporate PREPS policy.

The application of the local policy meant that prisoners on Standard level, who misused drugs, knew that they would not have to take voluntary drug tests on a random basis. They would not, therefore, have to consider the possibility of demotion to the Basic regime and loss of privileges.

The Prisoner Ombudsman made an early recommendation on 1 July 2009 about the arrangements for drug testing in connection with PREPS, at Magilligan. This is included at the recommendations section of this report on page 22, along with the Prison Service's response.

Magilligan Prison is now, in line with a new PREPS policy, carrying out random drug tests on prisoners across all three regimes.

30a. Prison Service policy at the time of Richard's death stated that random voluntary drug testing should apply to all prisoners on Basic, Standard and Enhanced regimes

30b. At the time of Richard's death, Magilligan Prison operated a local policy which stipulated that only prisoners on the Enhanced Regime, those taking home leave and those on drug free wings should be subject to random voluntary drug tests.

30c. Richard was on the Standard Regime and was not, therefore, subject to random voluntary drug tests.

30d. The urine analysis method of drug testing was only available at certain times, did not produce results in a timely manner and was open to abuse.

30e. The drug testing unit at Magilligan Prison was not permanently staffed. Staff were at times required to close the unit in order to carry out other duties.

30f. In October 2009, the Prison Service, in response to an early recommendations made on 1 July 2009, stated that they anticipated Swab Testing would be introduced by the end of 2009. Swab testing has not yet been introduced but information has been sought on the revised plans for its implementation.

31. The Communication of Drug Test Results

Richard passed a drug test on 12 September 2008, for the purpose of moving to drugs free accommodation. Richard failed a test on 10 October 2008 when he was put forward for promotion to Enhanced level. As part of Richard's conditions for his home leave he passed his test on 6 January 2009. However he failed his test on 9 January 2009 when he returned to prison. The healthcare team, Offender Management Unit and Northlands drugs counsellors were not informed of these results.

In line with normal practice, the test results were entered onto the Prison Service's database known as PRISM, which is accessible to all prison staff.

The information is not routinely fed back to the above agencies and departments but they can access PRISM. If, however, they do not constantly check PRISM, they may be unaware that a drug test has been administered and may miss critical information about results.

Without this information, the assessment of a person's ability to monitor and manage their in-possession medication may not be accurate. Similarly, as in Richard's case, drugs counsellors may be unaware that information provided by a prisoner is untrue.

The Northern Ireland Prison Service policy on Alcohol and Substance Misuse comprehensively documents the inter agency co-operation required to ensure full delivery of this Policy.

Information on whether or not individuals have passed or failed drug tests may be important to the Probation Service, Offender Management Unit, drug addiction counselling services, Healthcare Department and others included in monitoring and supporting a prisoner's progress.

The Prisoner Ombudsman made early recommendations on 1 July 2009 about the communication of the results of drugs tests to those who need to know. This is included at the recommendations section of this report on page 22, along with the Prison Service and South Eastern Health and Social Care Trust's response.

31a. At the time of Richard's death, there was no process in place for the results of drugs tests to be notified to healthcare staff and Offender Management Unit.

32. Drug and Alcohol Rehabilitation Services

Within the Northern Ireland Prison Service Alcohol and Substance Misuse Policy, a strong emphasis has been placed on adopting a multi-agency approach to re-educate and provide rehabilitation and treatment for prisoners with addictions as well as through care when a prisoner's time is served.

At the time of Richard's death, the addictions counselling services in Magilligan were provided by Northlands. Northlands is a community based independent alcohol and drug treatment centre which set up a joint partnership with Magilligan in 2000. The joint partnership provided a range of programmes to support people with alcohol and substance misuse and addiction, in order to help them to achieve a good recovery.

Referrals to Northlands could be made by any member of staff and this could be done with or without the consent of the individual concerned. However, referrals were usually made by the resettlement board and the individual being referred would usually be advised that they were being referred for an assessment by Northlands.

The resettlement board includes representatives from Probation, Education and Training, the Offender Management Unit, Psychology, Niacro[25] and a Drug and Alcohol counsellor. All prisoners are reviewed by the resettlement board to consider their individual needs and offer them support to try and reduce the risk of reoffending. A range of support programmes are

[25] Niacro – A voluntary organisation that works for the welfare of the offender in order to work towards reducing crime and its impact on people and the communities.

available to those with alcohol and substance misuse and addiction problems.

32a. At the time of Richard's death, Drug and Alcohol counselling services were in place at Magilligan Prison.

33. Mobile Phones

The Report on Minimising the Supply of Drugs in Northern Ireland Prisons (July 2008) states, *"there is a link between the use of mobile phones by prisoners and the use and supply of drugs."*

Between October 2008 and March 2009, 28 mobile phones were recovered in Magilligan Prison.

With advances in technology, mobile phones in prisons present a significant security threat by allowing unmonitored communications and internet access.

There is evidence that mobile phones are often brought into prison in body cavities, and in the absence of the available technology to fully x-ray a person, detecting mobile phones concealed in body cavities is difficult.

B.O.S.S Chairs

A high sensitivity metal detector designed to detect metal objects hidden in body cavities, known as a B.O.S.S chair, is used in all prisons across England and Wales to scan prisoners for weapons and prohibited articles hidden in body cavities. In England and Wales the B.O.S.S chair can be used to scan prisoners, social, official and professional visitors and staff under Prison Rules.

As a result of the introduction of these B.O.S.S chairs, the numbers of mobile phones and SIM cards found have almost doubled. The Ministry of Justice figures show almost 9,000

mobile phones and SIM cards were seized during 2008 - up more than 5,800 on two years earlier.

B.O.S.S chairs are not used in Magilligan Prison or other establishments across the Northern Ireland Prison Service. The Security Governor at Maghaberry Prison (Gov Ivor Martin) confirmed that some years ago the Prison Service borrowed a B.O.S.S chair from the Scottish Prison Service and that they still have it. The Security Governor stated that evaluation tests were carried out which concluded that there was no real benefits to be gained by the deployment of such equipment in the Prison Service. It was felt that staff could achieve the same result by using the latest generation of hand held metal detectors.

33a. Between October 2008 and March 2009, 28 mobile phones were recovered in Magilligan Prison.

33b. There is a link between the use of mobile phones within prison and the use and supply of drugs.

33c. B.O.S.S chairs have been shown to significantly impact upon the level of detection of mobile phones in England and Wales.

33d. The Prison Service of Northern Ireland has in their possession a B.O.S.S chair but says that its evaluation suggests that there is no benefit to be gained by deployment of such equipment in Northern Ireland. They believe that the same results can be achieved using the latest generation hand held metal detectors.

Mobile Phone Blockers

The Prison Service is researching the feasibility of introducing mobile phone blockers across all establishments. In an early recommendation made on 1 July 2009, I reiterated a previous recommendation that the Prison Service install approved technology to block the use of mobile phones in all prisons. This is included at the recommendations section of this report on page 22, along with the Prison Service's response.

The Irish Prison Service has carried out a pilot scheme of inhibiting the use of mobile phones in their prisons and a further module of that pilot scheme is understood to be ongoing. Three other pilot schemes in Limerick, Mountjoy and Cloverhill Prisons are at advanced stages of planning. Each of the four schemes uses different technology and when completed, there will be a tendering process to select a service provider to introduce inhibition to all closed prisons.

The Northern Ireland Prison Service stated that they are also continuing to monitor ongoing pilots in England and Wales and the Irish Prison Service. The Prison Service further stated that it has availed of the opportunity to purchase a number of mobile detectors.

33e. The Prison Service are investigating the use of mobile phone blockers. The developments of plans in English and Irish Prison Services are being monitored.

34. Visits

Richard's family raised a concern about how it was possible to get drugs into Magilligan Prison. There is evidence that one of the ways that drugs enter Magilligan Prison is that they are brought in by prisoners and visitors.

Information provided by an officer on H1 C and D wing stated that the misuse of drugs was a regular occurrence, *"especially when prisoners were returning from visits and in particular returning from home leave."*

The Governing Governor at Magilligan Prison strongly believes that there is a balance to be achieved between proportionate management of the visitor's area that does not wrongly penalise those who are innocent of any wrong doing and the prevention of drugs being brought into prison.

Magilligan Prison operates a pre-booked visits system enabling visitors to book visits on a day and at a time that suits them best. The number of visits permitted varies depending on the regime level of the person being visited.

On entering the prison, visitors enter a security area where they are all required to go through a full rub down search and a search by a passive drugs dog for prohibited substances. Personal belongings must be left in a specially provided area and parcels are collected and searched before being issued to prisoners. Once visitors have been cleared through the security area they are permitted to continue to the main visits room.

The investigation found that the walkway between the security room and the main visits room was not supervised or monitored by CCTV, thus providing an area whereby those visitors

attempting to smuggle drugs into the prison could remove hidden substances and conceal them in readiness to pass them to the person they are visiting, without being seen.

Once visits have finished, all prisoners are required to move through a search room where a full or rub down search is carried out. The investigation found that prisoners wait in an unsupervised enclosed corridor between the visits room and search room whilst waiting to be searched. This arrangement provides opportunities for prisoners, who are attempting to smuggle prohibited articles or substances into the prison, to pass the items to other prisoners who they consider less likely to be fully searched.

The Prisoner Ombudsman made two early recommendations on 1 July 2009 in connection with security in the visits area of Magilligan Prison. These are included at the recommendations section of this report on page 22, along with the Prison Service's response.

34a. The walkway between the visits security room and the main visits area at Magilligan is not monitored by CCTV or supervised by staff. This provides an opportunity for visitors smuggling prohibited articles or substances into prison to conceal the items before they meet their family member or friend.

34b. The waiting area for prisoners between the visits area and the search room is enclosed and unsupervised providing prisoners with an opportunity to pass smuggled items to other prisoners who are less likely to be fully searched.

35. Report on Minimising the Supply of Drugs in the Northern Ireland Prison Service

As a response to concern about the increase in drug related incidents, and evidence of increased misuse of drugs in each of the prisons, the Northern Ireland Prison Service in July 2008, developed a project to research areas of concern and published the results.

As a result of the findings of the Project Group, 28 recommendations were produced. These included recommendations relating to:

- Staff Training
- Entry and Exit Points
- Visits
- Searches
- Passive Drugs Dogs
- Use of Intelligence
- Drug Testing
- Search Facilities
- Detection Equipment.

An Action Plan was produced by the Prison Service in respect of the recommendations made but an audit of the implementation of the plan has not yet taken place.

The requirement for a comprehensive audit of the implementation of this Action Plan is included in the recommendations section on page 22.

APPENDICES

APPENDIX 1

TERMS OF REFERENCE FOR INVESTIGATION OF DEATHS IN PRISON CUSTODY

1. The Prisoner Ombudsman will investigate the circumstances of the deaths of the following categories of person:

   - **Prisoners (including persons held in young offender institutions). This includes persons temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It excludes persons released from custody, whether temporarily or permanently. However, the Ombudsman will have discretion to investigate, to the extent appropriate, cases that raise issues about the care provided by the prison.**

2. The Ombudsman will act on notification of a death from the Prison Service. The Ombudsman will decide on the extent of investigation required depending on the circumstances of the death. For the purposes of the investigation, the Ombudsman's remit will include all relevant matters for which the Prison Service, is responsible, or would be responsible if not contracted for elsewhere. It will therefore include services commissioned by the Prison Service from outside the public sector.

3. The aims of the Ombudsman's investigation will be to:

- Establish the circumstances and events surrounding the death, especially as regards management of the individual, but including relevant outside factors.

- Examine whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence.
- In conjunction with the DHSS & PS, where appropriate, examine relevant health issues and assess clinical care.
- Provide explanations and insight for the bereaved relatives.
- Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.

4. Within that framework, the Ombudsman will set terms of reference for each investigation, which may vary according to the circumstances of the case, and may include other deaths of the categories of person specified in paragraph 1 where a common factor is suggested.

Clinical Issues

5. The Ombudsman will be responsible for investigating clinical issues relevant to the death where the healthcare services are commissioned by the Prison Service. The Ombudsman will obtain clinical advice as necessary, and may make efforts to involve the local Health Care Trust in the investigation, if appropriate. Where the healthcare services are commissioned by the DHSS & PS, the DHSS & PS will have the lead responsibility for investigating clinical issues under their existing procedures. The Ombudsman will ensure as far as possible that the Ombudsman's investigation dovetails with that of the DHSS & PS, if appropriate.

Other Investigations

6. Investigation by the police will take precedence over the Ombudsman's investigation. If at any time subsequently the Ombudsman forms the view that a criminal investigation should be undertaken, the Ombudsman will alert the police. If at any time the Ombudsman forms the view that a disciplinary investigation should be undertaken by the Prison Service, the Ombudsman will alert the Prison Service. If at any time findings emerge from the Ombudsman's investigation which the Ombudsman considers require immediate action by the Prison Service, the Ombudsman will alert the Prison Service to those findings.

7. The Ombudsman and the Inspectorate of Prisons will work together to ensure that relevant knowledge and expertise is shared, especially in relation to conditions for prisoners and detainees generally.

Disclosure of Information

8. Information obtained will be disclosed to the extent necessary to fulfil the aims of the investigation and report, including any follow-up of recommendations, unless the Ombudsman considers that it would be unlawful, or that on balance it would be against the public interest to disclose particular information (for example, in exceptional circumstances of the kind listed in the relevant paragraph of the terms of reference for complaints). For that purpose, the Ombudsman will be able to share information with specialist advisors and with other investigating bodies, such as the DHSS & PS and social services. Before the inquest, the Ombudsman will seek the Coroner's advice regarding disclosure. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Reports of Investigations

9. The Ombudsman will produce a written report of each investigation which, following consultation with the Coroner where appropriate, the Ombudsman will send to the Prison Service, the Coroner, the family of the deceased and any other persons identified by the Coroner as properly interested persons. The report may include recommendations to the Prison Service and the responses to those recommendations.

10. The Ombudsman will send a draft of the report in advance to the Prison Service, to allow the Service to respond to recommendations and draw attention to any factual inaccuracies or omissions or material that they consider should not be disclosed, and to allow any identifiable staff subject to criticism an opportunity to make representations. The Ombudsman will have discretion to send a draft of the report, in whole or part, in advance to any of the other parties referred to in paragraph 9.

Review of Reports

11. The Ombudsman will be able to review the report of an investigation, make further enquiries, and issue a further report and recommendations if the Ombudsman considers it necessary to do so in the light of subsequent information or representations, in particular following the inquest. The Ombudsman will send a proposed published report to the parties referred to in paragraph 9, the Inspectorate of Prisons and the Secretary of State for Northern Ireland (or appropriate representative). If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Publication of Reports

12. Taking into account any views of the recipients of the proposed published report regarding publication, and the legal position on data protection and privacy laws, the Ombudsman will publish the report on the Ombudsman's website.

Follow-up of Recommendations

13. The Prison Service will provide the Ombudsman with a response indicating the steps to be taken by the Service within set timeframes to deal with the Ombudsman's recommendations. Where that response has not been included in the Ombudsman's report, the Ombudsman may, after consulting the Service as to its suitability, append it to the report at any stage.

Annual, Other and Special Reports

14. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Secretary of State for Northern Ireland. The Ombudsman may also publish material from published reports in other reports.

15. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Secretary of State for Northern Ireland.

16. Annex ‘A’ contains a more detailed description of the usual reporting procedure.

REPORTING PROCEDURE

1. The Ombudsman completes the investigation.

2. The Ombudsman sends a draft report (including background documents) to the Prison Service.

3. The Service responds within 28 days. The response:
   (a) draws attention to any factual inaccuracies or omissions;
   (b) draws attention to any material the Service consider should not be disclosed;
   (c) includes any comments from identifiable staff criticised in the draft; and
   (d) may include a response to any recommendations in a form suitable for inclusion in the report. (Alternatively, such a response may be provided to the Ombudsman later in the process, within an agreed timeframe.)

4. If the Ombudsman considers it necessary (for example, to check other points of factual accuracy or allow other parties an opportunity to respond to findings), the Ombudsman sends the draft in whole or part to one or more of the other parties. (In some cases that could be done simultaneously with step 2, but the need to get point 3 (b) cleared with the Service first may make a consecutive process preferable.)

5. The Ombudsman completes the report and consults the Coroner (and the police if criminal investigation is ongoing) about any disclosure issues, interested parties, and timing.

6. The Ombudsman sends the report to the Prison Service, the Coroner, the family of the deceased, and any other persons

identified by the Coroner as properly interested persons. At this stage, the report will include disclosable background documents.

7. If necessary in the light of any further information or representations (for example, if significant new evidence emerges at the inquest), the Ombudsman may review the report, make further enquiries, and complete a revised report. If necessary, the revised report goes through steps 2, 3 and 4.

8. The Ombudsman issues a proposed published report to the parties at step 6, the Inspectorate of Prisons and the Secretary of State (or appropriate representative). The proposed published report will not include background documents. The proposed published report will be anonymised so as to exclude the names of individuals (although as far as possible with regard to legal obligations of privacy and data protection, job titles and names of establishments will be retained). Other sensitive information in the report may need to be removed or summarised before the report is published. The Ombudsman notifies the recipients of the intention to publish the report on the Ombudsman's website after 28 days, subject to any objections they may make. If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so.

9. The Ombudsman publishes the report on the website. (Hard copies will be available on request.) If objections are made to publication, the Ombudsman will decide whether full, limited or no publication should proceed, seeking legal advice if necessary.

10. Where the Prison Service has produced a response to recommendations which has not been included in the report, the Ombudsman may, after consulting the Service as to its suitability, append that to the report at any stage.

11. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Secretary of State for Northern Ireland. The Ombudsman may also publish material from published reports in other reports.

12. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Secretary of State for Northern Ireland. In that case, steps 8 to 11 may be modified.

13. Any part of the procedure may be modified to take account of the needs of the inquest and of any criminal investigation/proceedings.

14. The Ombudsman will have discretion to modify the procedure to suit the special needs of particular cases.

APPENDIX 2

MAGILLIGAN PRISON

Background Information

Magilligan is a medium security prison housing sentenced adult male prisoners which also contains low security accommodation for selected prisoners nearing the end of their sentence. It was opened in 1972 and major changes were made in the early 1980s. Three H-Blocks together with Halward House and the low-security temporary buildings of Foyleview, Sperrin and Alpha make up the present residential accommodation. It is one of three detention establishments managed by the Northern Ireland Prison Service, the others being Maghaberry Prison and Hydebank Wood Prison and Young Offenders Centre.

The prison accommodates an average of 400 adult males who have between six years and one year of their sentence left to serve. On the day Richard died Magilligan held 427 prisoners.

The regime in Magilligan focuses on a balance between appropriate levels of security and the Healthy Prisons Agenda[26] – safety, respect, constructive activity and addressing offending behaviour. Purposeful activity and offending behaviour programmes are a critical part of the resettlement process. In seeking to bring about positive change, staff develop prisoners through a Progressive Regimes and Earned Privileges Scheme (PREPS) as in other prisons.

[26] Healthy Prisons Agenda-The concept of a healthy prison is one that was first set out by the World Health Organisation, but it has been developed by the HM Inspectorate of Prisons. It is now widely accepted as a definition of what ought to be provided in any custodial environment.

POLICIES AND PRISON RULES

The following is a summary of Prison Service policies and procedures relevant to my investigation. They are available from the Prisoner Ombudsman's Office on request.

Prison Rules

Rule 27(1) of The Prison and Young Offenders Centres Rules (Northern Ireland) 1995 gives the authority under which a prisoner can be temporarily released from custody, as follows:

Temporary release
27. – (1) A prisoner to whom this rule applies may be temporarily released for any period or periods and subject to any conditions.
(2) A prisoner may be temporarily released under this rule for any special purpose or to enable him to have medical treatment to engage in employment, to receive Instruction or training or to assist him in his transition from prison to outside life.
(3) A prisoner released under this rule may be recalled to prison at any time whether the conditions of his release have been broken or not.
(4) This rule applies to prisoners other than persons-

(a) remanded in custody by any court; or

(b) committed in custody for trial; or

(c) committed to be sentenced or otherwise dealt with before or by the Crown Court.

Rule 38 (19) of The Prison and Young Offenders Centres Rules (Northern Ireland) 1995 states A prisoner shall be guilty of an offence against prison discipline, if he prepares, manufactures, consumes, inhales or administers to himself or any other person, with

or without consent, any intoxicating substance or drug, or buys, sells, passes or possesses any such item.

Rule 83 (1) of The Prison and Young Offenders Centres Rules (Northern Ireland) 1995 gives the authority under which a prisoner can be given or allowed to have intoxicating liquor or drugs:

Alcohol, drugs and tobacco
83. (1) A prisoner shall not be given or allowed to have any intoxicating liquor or drug except under a written order of the medical officer specifying the nature and quantity and the name of the prisoner for whose use it is ordered.

Standard Operating Procedures

Section C – Duty of Care – "Drug and Alcohol (Supply reduction, monitoring and drug testing)" details the operational performance standard for staff in establishments to work to, to ensure a continuing reduction in the availability of illicit drugs, alcohol and any misuse of prescription drugs through a range of supply reduction measures.

Section C of the Operational Performance Standards manual fully details what the policy covers, the monitoring arrangements in place including the gathering of statistics for analysis, the procedures and systems in place for the detection, deterring and prevention of drugs entering the prison, and the training that should be provided for staff dealing with prisoners who misuse drugs and alcohol.

Death in Custody Contingency Plan

The Death in Custody Contingency Plan provides step by step guidance for all staff in how to deal with and manage the death of a prisoner in custody.

Governor's Orders

Governor's Orders are specific to each prison establishment. They are issued by the Governor to provide guidance and instructions to staff in all residential areas on all aspects of managing prisoners.

Governor's Order L.8 'Action To Be Taken By Healthcare Staff On Receipt Of Information Or A Suicide, Attempted Suicide Or Other Emergency Incident': sets out guidance and instruction to staff on how they should immediately respond to such an incident during the day or night.

Governor's Order S.7 'Pegging, Body Checks and Reporting Procedures by Night Custody Staff': provides information and instructions to staff on how prisoners should be checked at specific times of the night and to ensure there are no defects in the fabric of the establishment.

Governor's Order S.8 'Night Custody Emergency Unlock': sets out what actions staff must carry out in the event of a life threatening situation.

PREPS – Progressive Regime and Earned Privileges

PREPS hinges on motivating prisoners to engage with the constructive activities outlined on their agreed resettlement plan. Constructive activities include any form of training, education, work or other activity, as specified on the plan. PREPS works towards these objectives of allocating privileges according to different regime levels. Privilege and regime levels are based on a three tier system: Basic, Standard and Enhanced.

APPENDIX 3

The Prisoner Ombudsman for Northern Ireland

22nd Floor, Windsor House, Bedford Street, Belfast BT2 7FT
Tel: 028 90443998 Fax: 028 90443993

Mr Robin Masefield
Director
NI Prison Service
Room 314
Dundonald House
BELFAST
BT4 3SU

1ST July 2009

Dear Robin

PRISONER OMBUDSMAN INVESTIGATION INTO THE DEATH IN CUSTODY OF RICHARD GILMORE

As with the investigation into the death of Colin Bell I have decided to forward recommendations in respect of the death of Richard Gilmore in two phases. In view of the circumstances surrounding Richard's death, it was my view that it would be appropriate to communicate some recommendations in advance of my main report.

I am aiming to have my report ready to discuss with Richard's family and yourself in around six to eight weeks time. I will however, review this timescale if I consider it necessary when I have been fully briefed on the content of the interviews currently being undertaken by my investigators.

I believe that immediate action in respect of these recommendations may impact upon the risk of a similar death occurring. I am aware that some of these issues have been raised in previous reports, and I will discuss this further in my final report.

All the observations and recommendations listed in the Appendix will be included in my final report. In making these recommendations I wish to emphasise that, having spoken at length with Tom Woods, I am very supportive of his efforts to create at Magilligan an environment that aims to

give prisoners with addiction problems every chance to pick themselves up when they fail drugs tests or get into difficulties, and is proportionate in its response. I understand the very difficult challenge of achieving an appropriate balance.

I hope these recommendations will be seen as helpful and I would appreciate receiving as soon as possible, your response to them so that I can reflect these in my final report.

I will, in accordance with my terms of reference, forward copies of this letter to the Minister, once you have confirmed that there are no factual accuracy issues.

Yours sincerely

PAULINE MCCABE
Prisoner Ombudsman for Northern Ireland

APPENDIX A

Investigation into the circumstances surrounding the death of Richard Gilmore in Magilligan Prison on 11 January 2009

From my preliminary investigations into the circumstances surrounding the death of Richard Gilmore, I identified the following areas of concern and included recommendations or action points, where appropriate. The Prison Service provided its response

ISSUES EMERGING	RECOMMENDATIONS / ACTION POINTS	
DRUG STRATEGY		**NIPS RESPONSES**
PREPS Policy and Voluntary Drug Testing – NIPS Corporate PREPS Policy states: "Prisoners on all three regime levels will be subject to voluntary drugs testing and at regime level progression testing stage." At the time of Richard's death, Magilligan Prison was working to a local PREPS policy document in respect of voluntary drug testing. This policy states that only Enhanced prisoners have to successfully pass a voluntary drug test and agree to random testing thereafter.	**Recommendation** – I recommend that NIPS ensure random voluntary drug testing is extended to cover all standard prisoners in Magilligan Prison. **"Note**: *I am aware of the recent introduction of a new PREPS policy, which was being worked on prior to Richard's death, and includes provision for random drugs tests of all standard prisoners. We are also aware that the Governor of Magilligan Prison has plans, consistent with this, to introduce a prisoner contract, which we welcome."*	**Accepted** With effect from 13th July 2009 voluntary drug testing will be offered to all prisoners irrespective of regime level. However, NIPS cannot presently require prisoners to provide a urine sample – this will change in the autumn when Prison Rules are changed to provide enabling powers for NIPS to introduce mandatory drug testing. Magilligan are proactive in following up any prisoner on basic regime to ensure they are offered every support and encouragement to address their issues, including those who misuse drugs in

From reviewing the records of voluntary drug tests carried out in Magilligan, standard prisoners are only tested for progression to Enhanced, when going out/in for Home Leave and Town Visits or being on a drug free wing. They are not usually randomly tested.		order to facilitate a return to standard regime. Currently 13 prisoners have refused to sign a Prisoner PREPS Contract. Interviews are taking place to determine reasons why and explain consequences of not doing so.
Drug Free Wings – The investigation to date would suggest there is a general acceptance that drug free wings are not drugs free and that this is detrimental to the objective of encouraging prisoners to remain drugs free.	**Recommendation** – I recommend that NIPS ensure drugs free wings are required to be drugs free and that any prisoner failing a drugs test, or found with drugs, is immediately required to leave the wing. I do support the view that prisoners, removed from the wing for failing a drugs test, should be given every support to get back to the drugs free wing as soon as possible. **Recommendation** – I further recommend that the frequency of random drugs testing of prisoners located in the drugs free wings, where prisoners have the benefit of a new modern facility, should be reviewed to ensure that the likelihood of maintaining a drugs free environment is maximised.	**Accepted** Two hundred and fifty cells (Halward House, Sperrin, Alpha, Foyleview) are set as a progressive regime within a drug free environment. We have a zero tolerance to presence of drugs and failure of drugs tests. Prisoners are transferred from these areas if they fail drug tests but regular reviews and case conferences provides the opportunity for prisoners to demonstrate progress and facilitate their return to drug free accommodation, including Foyleview. **For Further Consideration** Using current urine drug testing procedures we have finite staff resources and limited time to carry out drug tests given the pressures of managing an ever increasing prisoner population. Increase in drug testing in any area of the prison is based on intelligence and prisoner behaviour. However, NIPS is currently tendering to introduce saliva testing which will hopefully be available this

		autumn, and which will provide for a more convenient test requiring the prisoner to provide a saliva sample which can then be sent to the laboratory. The new arrangement will not require dedicated staff or a dedicated testing area.
Drug Testing Process – The current method used for drug testing is by way of providing a urine sample. This method allows the prisoner 4 hours to produce their sample which is time consuming for the staff involved and provides an opportunity for prisoners to provide diluted samples, or samples which are not their own. It is also to note that the current service level agreement between NIPS and their outsourced drug testing facility only provides for samples to be sent for testing twice a week, with a turnaround of up to a week for the result to be received. Swab Testing has been piloted within NIPS and positive feedback has been received from staff and prisoners in respect of the efficiency and ease of administration, including speed of turnaround of results.	**Recommendation –** I recommend that NIPS should introduce the new Swab Test, which is easy to administer and provides results much sooner, at the earliest opportunity.	**Accepted** Swab Testing procedures are required to go through a contract tendering process. It is anticipated Swab Testing will be introduced by the end of 2009.
Notification of Drug Test Results – When a prisoner fails a drug test it would	**Recommendation –** I recommend that Magilligan Prison introduce a system	**Accepted** Currently failed drug tests are recorded

appear that this information is not always communicated to the Healthcare Department or Offender Management Unit, which encompasses prisoner counselling services. While this information is available on PRISM, there are no automatic notifications in place. This information may be relevant to prescribing decision, self medication decision and to decisions about the support provided to help a prisoner become drug free.	whereby failed drug test results are always notified to Healthcare. I extend this recommendation to all Northern Ireland Prison establishments, if relevant. **Recommendation –** I further recommend that NIPS introduce a system whereby failed drug tests are notified to the Offender Management Unit. I extend this recommendation to all Northern Ireland Prison establishments, if relevant.	on PRISM. Failed drug tests will be notified to Healthcare and the Offender Management Unit (OMU). **Accepted** Accepted; as above failed drug tests are recorded on PRISM and will be notified to Healthcare and the OMU (which is the successor to the PDU).
DRUG RELATED SECURITY MEASURES		
Recording of Security Information Reports (SIR) – On the night of 9th January 2009, the night custody officer in H1 C&D suspected prisoners of smoking cannabis and being "off their faces". A handwritten note on a plain piece of paper was handed to security the following morning, where it was subsequently transferred onto an SIR by Security Staff. The same information was not recorded in the Wing Journal.	**Recommendation –** I recommend that NIPS take steps to ensure that Officers fully record in the Wing Journals, details of information supplied to or requests directed to Security Staff, which would provide important information impacting on the duty of care provided by officers across subsequent shifts.	**Partially Accepted** It is not appropriate to record all sensitive information in a wing journal which might be seen by prisoners. However, information of a sensitive nature which impacts on security, good order and control within the residential area should be recorded in the Residential Manager's journal and should be available to other managers who can then brief their staff accordingly. In addition, there is a well established Security Information Reporting System which allows staff to provide information to Security directly. Staff coming on duty should be briefed by the managers on any developments which occurred during the previous shift.

As a result of this SIR, searches were carried out on the morning of 10th January 2009. It is further noted that while the searches were recorded in the Wing Journal, there was no record of the result of these searches recorded.	**Recommendation** – I further recommend that NIPS take steps to ensure that the results of searches are also recorded in the Wing Journal in order that Wing Staff are fully informed of substances found etc.	**Partially Accepted** As outlined above, it is not appropriate to record sensitive information in the Wing Journal. Such information should only be recorded in the Residential Manager's journal and should be available for briefing staff at shift hand-overs.
Intelligence Led Searches – From reviewing the CCTV of H1 D Wing on 10th January 2009, it is clear that prisoners were alerted to the unscheduled lock-down that began taking place at 0929 hrs. in preparation for cell searches, with Richard Gilmore not being locked in his cell until 0937 hrs. The CCTV footage shows the delay gave prisoners an opportunity to organise themselves and conceal or destroy any prohibited substances throughout the Wing, prior to the searches taking place.	**Recommendation –** I recommend that Magilligan Prison carries out a review into how cell searches are planned and monitored in order to minimise the opportunity for drugs to be concealed or disposed of.	**For Further Consideration by Local Management** Cells are routinely searched by residential staff. However, where there is specific intelligence to suggest that there is a significant problem in a specific area, a special search will be organised. This does require time to plan given the requirement to muster staff as Magilligan does not have a dedicated staff search team. Every effort is made to ensure intelligence led searches are conducted without prisoners being aware, but inevitably when staff appear at the block in large numbers, prisoners will quickly become aware something is about to take place. They will then make whatever efforts they can to dispose of contraband, which includes both swallowing and inserting in body cavities.
Mobile Phones – Mobile phones appear to play a significant role in the supply and demand of drugs within Magilligan Prison. This is an issue which has been	**Recommendation –** I reiterate a previous recommendation that NIPS install approved technology to block the use of mobile phones in all prisons. I note that	**Accepted in Principle** NIPS are continuing to monitor ongoing pilots in England & Wales, and IPS. NIPS

highlighted in previous death in custody investigations where the following recommendation was made: *"that the Prison Service urgently seeks the necessary approval for the installation of approved technology to block mobile phone signals in all prisons within Northern Ireland."*	current research NIPS are undertaking in respect of this and would recommend that appropriate decisions are made at the earliest opportunity. **Recommendation –** I further recommend that NIPS research, at the earliest opportunity, the feasibility of using mobile phone detectors which are currently available on the market.	have availed of the opportunity to purchase a limited number of mobile detectors and indeed mobile, local blockers.
EMERGENCY/MEDICAL UNLOCKS		
On the evening of 10th January 2009 a medical emergency unlock took place on H1 D Wing resulting in the prisoner being admitted to hospital with a suspected drugs overdose. As a result of this incident, the Night Custody Officers took it upon themselves to carry out an extra body check.	**Recommendation –** I recommend that NIPS carry out a review of the level of supervision all prisoners receive on a Wing following such an incident and that this should not rely on Landing Officers/Night Custody Officers using their discretion. **Recommendation –** I further recommend that arrangements should be put in place for informing prisoners where a drug related incident of this kind has occurred, and for prisoners to be given the opportunity, and encouraged, to come forward with any information or concerns they may have without any repercussions.	**For Further Consideration by Local Management** It is impossible to be prescriptive to cover all situations. Supervising staff are required to use their discretion to introduce additional checks where this is considered necessary. It is also right that NCOs use their discretion also if they have a specific concern. **Accepted** This is accepted practice depending on the seriousness of an incident. Magilligan has advised prisoners of drug 'amnesties' on several occasions in the past.

VISITS		
We note and welcome the work being carried out by the Governor to improve and develop the area where visitors enter and meet their family member or friend. However, we note there are areas which may be vulnerable when trying to prevent drugs being brought into the prison.	**Recommendation –** I recommend that Magilligan Prison carry out a review of the adequacy of security in the area where visitors move between the Security area and the Main Visits Room.	**Accepted** Plans are well advanced to provide an extension to the existing visiting facility. Magilligan Security will review the existing security arrangements, particularly monitoring of movement in this area to ensure there is adequate CCTV cover and any improvements will be brought forward as part of the refurbishment work.
In particular we note that: i. The area between the Security area and the Main Visits Room is not supervised or monitored by CCTV. ii. Prisoners leaving the Visits Room wait in an enclosed, unobserved corridor prior to entering the Search Room. This arrangement provides an unsupervised opportunity for prisoners who are carrying prohibited articles or substances to pass the items they are holding to other prisoners who are less likely to be fully searched. We should emphasise that we also support the Governor's view of the need for proportionate management of the visitors' area that does not wrongly penalise those who are innocent of any wrong-doing.	**Recommendation –** I recommend that Magilligan Prison carry out a review on the current arrangements for prisoners leaving the Visits Room. **"Note:** *I have been informed that the Governing Governor plans to erect a tunnel with CCTV coverage between the Security area and Visits Room. This is to be welcomed and I would recommend that this be implemented on a matter of urgency."*	An internal tunnel/covered walkway is ready for installation once the Visits extension is completed.