The Prisoner Ombudsman for Northern Ireland

OFFICIAL - SENSITIVE

INVESTIGATION REPORT
INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

MR EMMETT CASSIDY
AGED 28
WHILE IN THE CUSTODY OF MAGHABERRY PRISON
ON 11th DECEMBER 2018

Date finalised: **11 March 2022**

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The role of the Prisoner Ombudsman

The Prisoner Ombudsman for Northern Ireland is responsible for providing an independent and impartial investigation of deaths in prison custody in Northern Ireland. This includes the deaths of people shortly after their release from prison and incidents of serious self-harm.

The purpose of the Prisoner Ombudsman's investigation is to find out, as far as possible, what happened and why, establish whether there are any lessons to be learned and make recommendations to the Northern Ireland Prison Service (the Prison Service) and the South Eastern Health and Social Care Trust (the Trust) for improvement, where appropriate.

By highlighting learning to the Prison Service, the Trust and others who provide services in prisons, the Ombudsman aims to promote best practice in the care of prisoners.

The objectives of death in custody investigations are set out in the Ombudsman's terms of reference and are to:

- establish the circumstances and events surrounding the death, including the care provided by the Prison Service;
- examine any relevant healthcare issues and assess the clinical care provided by the Trust;
- examine whether any changes in Prison Service or Trust operational methods, policy, practice or management arrangements could help prevent a similar death in future;
- ensure that the prisoner's family have an opportunity to raise any concerns they may have, and take these into account in the investigation; and
- assist the Coroner's investigative obligation 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 practice is identified, and any lessons from the death are learned.

Within the above objectives, the Ombudsman will identify specific matters to be investigated in line with the circumstances of an individual case.

In order that learning from investigations is spread as widely as possible, and in the interests of transparency, investigation reports are published on the Prisoner Ombudsman's website following consultation with the next of kin. Reports are also disseminated to those who provide services in prisons.

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Glossary

AA	Alcoholics Anonymous
AD:EPT	Alcohol and Drugs**:** Empowering People Through Therapy
CCTV	Close Circuit Television
CJINI	Criminal Justice Inspection Northern Ireland
CPR	Cardiopulmonary Resuscitation
ECR	Electronic Care Record
GP	General Practitioner
IMB	Internal Monitoring Board
MHMDTM	Mental Health Multi-Disciplinary Team Meeting
NICE	National Institute for Health and Care Excellence
NIPS	Northern Ireland Prison Service
PECCS	Prisoner Escorting and Court Custody Service
PIPE	Psychologically Informed Planned Environment
PREPS	Progressive Regimes & Earned Privileges Scheme
PRISM	Prisoner Record and Inmate System Management
PSST	Prisoner Safety and Support Team
SPAR	Supporting Prisoners At Risk (Procedure)
SPAR (EVO)	Supporting People At Risk (Evolution)
SEHSCT	South Eastern Health and Social Care Trust
SIR	Security Intelligence Report

Foreword from the Ombudsman

The death of a loved one is always difficult. The fact that a death occurs in custody, or shortly after someone is released from prison, has particular difficulties given the loss families experience when a loved one is taken into custody and the trust they must place in the Prison Service, the Trust, and others, to ensure the safety and wellbeing of their loved one.

All those in custody should expect to be treated decently and with respect, receiving the best care possible for their wellbeing and rehabilitation.

This report seeks to address and inform several interested parties, with the intention of them learning from the findings. While these interested parties are important to ensure change to care in custody, this report is written with Mr Cassidy's family primarily in mind. It is critical that, as far as we can, we provide explanations and insight to bereaved relatives. I am grateful to them for their contribution to this investigation and I appreciate their patience. I offer my sincere condolences to them on their sad loss and hope this report provides information to address some of the questions they raised and explains events leading up to Mr Cassidy's death. The learning, expressed in recommendations, will, I hope, bring some comfort to families who are grieving and confidence to those who have family members in custody.

Mr Cassidy died in hospital on 11 December 2018, after being found hanging in his cell in Maghaberry Prison on 07 December 2018. He was 28 years old.

He had a history of self-harm and struggled with addiction to drugs. He was remanded to Maghaberry Prison and had been granted bail but died before a suitable bail address could be provided. In the 15 weeks he was in custody he was managed under the Prison Service Supporting Prisoners at Risk procedures (SPAR) on three occasions. He had been referred to the prison's mental health team for a routine assessment which was completed. After consideration at a multi-disciplinary meeting, he was discharged from the mental health team caseload.

Two days before he was found hanging Mr Cassidy's mother raised concerns with the prison about his wellbeing. A prison officer checked on him shortly afterwards and was satisfied that there was no cause for concern at that time.

The Clinical Reviewer, Professor Jenny Shaw, concluded that Mr Cassidy's death could not have been predicted with any certainty and although there were missed opportunities in his care, these would not have prevented his death.

This investigation underlines the need for an important discussion about how the needs of people like Mr Cassidy can be better managed in prison.

Mr Cassidy was a vulnerable young man who had many problems. His life history indicates a number of risk factors (Section 4) including his addictions, bereavement and physical pain. Mr Cassidy's risk factors may be described as 'sub-diagnostic' in that his problems were below the threshold for secondary mental health care intervention. He is not alone within the prison population. This is the third case I examined in 2018 which, on the whole, the processes and procedures one might expect the Prison Service and the Trust to have in place were followed. What was lacking was some means of connecting a series of individual incidents to build a better understanding of Mr Cassidy's emotional pain and mental turmoil leading to a formulated plan to address his specific needs.

It seems to me that Mr Cassidy was asking for help in all sorts of ways but no-one could hear him because there was not an appropriate diagnostic pathway to define his needs and respond. I am very mindful that people in prison do not suddenly experience problems as they come through the prison gates. They bring their challenges with them. Prisons and their partner agencies then find themselves in the position of having to respond, often when this has not been possible in the community.

I recently raised a number of cases, 2 published[1] and 3 to be published, including that of Mr Cassidy, with the Prison Service and the Trust. I subsequently wrote to the Director, Reducing Reoffending, Department of Justice in August 2020 setting out the wider issues of concern which these cases raise and asking that they are considered by the joint Departmental Health and Justice Improving Health within Criminal Justice Implementation Group. I would like to see some innovative thinking and proposals developed and tested on how we might engage with people such as Mr Cassidy differently to improve their lives, keep them safe and reduce the risk of them reoffending.

At the time of writing a new Supporting People at Risk Procedure is in place across all prisons: SPAR Evolution (SPAR Evo). This new procedure should address concerns I and others have raised. SPAR Evo is now due for review and I hope the review will demonstrate improvements already made and further improvements to ensure the needs of prisoners are responded to effectively.

Additionally, a *Review of Services Provided to Vulnerable Persons Detained in Prisons in Northern Ireland* was published by the Regulation and Quality Improvement Authority (RQIA) in October 2021.[2] Recommendations in the Review Report will be critical to improving services, not least in addressing a more substantial and comprehensive needs assessment for people coming into custody. The more comprehensive needs assessments will then form a significant base of information

[1] Mr U and Mr Cassidy, https://niprisonerombudsman.gov.uk/
[2] https://www.rqia.org.uk/reviews/review-reports/2021-2022

and evidence to develop healthcare responses in relation to the healthcare needs of the prison population. The review recognises that it will take some time to develop a new approach to needs assessment. The significance of the needs assessment cannot be overstated and is recognised in RQIA's review as, for example, leading to an integrated model of care for mental health provision.[3] I welcome RQIA's review and its recommendations and look forward to contributing to the implementation of those recommendations where I can.

This report contains one recommendation that community records should be reviewed before a patient is discharged from the mental health team caseload, which was not accepted. The response to the recommendation is set out in Section 6 of this report.

I thank Mr Cassidy's mother for meeting with me. She told me about how her son had, as a young man, taken the decision to donate his organs. This was important information and reminded me again of the depth of loss families experience and the far-reaching impacts of their grief. It is critical to remember that each individual who dies in custody, as Mr Cassidy did, is a person with their own particular traits and in Mr Cassidy's case there was compassion for others. He chose to give hope to others by gifting his organs for donation in the event of his death. He received the *Order of St John Award for Organ Donation* which was recognition of his contribution and is tribute to the cherished memories he has left with his loved ones, particularly his mother.

I am also grateful to the Prison Service, the Trust and Professor Shaw for their contributions to this investigation. Others have helped in the information gathering process and to them I also extend my gratitude.

DR LESLEY CARROLL
Prisoner Ombudsman for Northern Ireland

[3] **Recommendation 6 (Priority 2):** Commissioners (currently the HSCB) and providers (SEHSCT) should work together to develop a service specification for an integrated model of care for mental health provision within the prison service; this should be informed by a robust needs assessment taking into account the needs of vulnerable people in custody. Underpinned by the right to health, there should be equitable seven-day provision across all prison sites. (p26)

Section 1: Background information – Maghaberry Prison

1.1 Maghaberry Prison

Maghaberry Prison is a high security prison, which holds male adult sentenced and remand prisoners. The population in the prison at the time of the incident involving Mr Cassidy was 806.

Maghaberry Prison has a Prisoner Safety and Support Team (PSST) whose responsibilities include supporting vulnerable prisoners.

Since 2008, the Trust have provided Prison Healthcare Services. There is a 24 hour Primary Healthcare Service and the Mental Health Team is on site Monday to Friday between 08:00 and 17:00. From 30 October 2020 this service became available seven days a week. Also from October 2020 all mental health committal triage has moved from being an in part paper based exercise to taking place face to face. There are no in-patient beds.

1.2 Criminal Justice Inspection (CJINI)

The most recent inspection of Maghaberry Prison was in April 2018 and the report was published in November 2018. Inspectors reported that Maghaberry Prison had settled considerably since the last full inspection in May 2015 and was now a much safer prison.

The overall picture of safety had progressed significantly and levels of violence and disorder had reduced. However, inspectors remained concerned that work to support the most vulnerable men at Maghaberry Prison had not developed to the same level as other aspects of safety.

The CJINI Safety of Prisoners Report, published jointly with RQIA in November 2019, highlighted that one of the most difficult issues facing the Prison Service was the identification of those more vulnerable people in the population. The report describes 'a concentration of need within prison establishments'[4] and emphasises remaining concerns that prisons do not provide, 'the therapeutic environment required for prisoners with complex needs…'[5] Recommendations in the RQIA report chime with my concerns about collaboration to ensure information is shared

[4] "The health profile of prisoners, the high level of mental ill-health, personality disorder, learning difficulty, drug and alcohol addiction, the proportion of prisoners on medication, and in numerous cases a combination of these factors, together with other vulnerability factors, all created a concentration of need within the prison establishments." The Safety of Prisoners held by the NIPS: A Joint Inspection by CJINI and the RQIA, November 2019, p11
[5] Ibid. p8

between agencies to ensure effective assessment of and response to prisoner needs. I reiterate the recommendation that the Trust and the Prison Service review and address the effectiveness of joint working so as to create a therapeutic environment to help stabilise individuals at risk and manage their imprisonment more safely.

1.3 Regional and Quality Improvement Authority (RQIA)

RQIA is the independent body responsible for regulating, inspecting and reviewing the quality and availability of health and social care services in Northern Ireland. Following events in 2016 when my Office carried out an investigation into a serious adverse incident and a number of suicides in prison, a review was commissioned by the Departments of Health and Justice to consider provision for particularly vulnerable persons in prison. The purpose of RQIA reviews is to identify best practice, highlight gaps or shortfalls in services where improvement is required and to protect the public interest. A long awaited report of the *Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons* was published on 05 October 2021. All recommendations are to be delivered within 18 months of publication of the report.

1.4 Independent Monitoring Board (IMB)

Maghaberry Prison has an IMB whose role is to satisfy themselves regarding the treatment of prisoners.

The 2018-19 IMB Annual Report for Maghaberry Prison reiterated continued improvement with the Core Day: a more structured approach to education and greater focus on reducing the amount of drugs coming into prison.

The IMB said that the prison was now a safer and more stable environment. The Board also reported significant changes in the field of safer custody including the introduction of updated operating procedures for Supporting People At Risk of suicide or self-harm.

As in previous years, IMB drew attention to the high percentage of prisoners in custody with mental health issues and substance/alcohol misuse problems, which often interlink. There were also prisoners diagnosed with Personality Disorder which does not come under the scope of the Mental Health (Northern Ireland) Order 1986 The Board acknowledged the challenges the Prison Service and the Trust had in terms of managing this client group and the care, compassion and understanding shown to these prisoners.

1.5 Prisoner Escorting and Court Custody Service (PECCS)

PECCS is responsible for the safe operation of the cell holding areas in each courthouse in Northern Ireland and were responsible for Mr Cassidy's care at court. PECCS staff also transferred Mr Cassidy safely to Maghaberry Prison.

1.6 Previous incidents at Maghaberry Prison

Mr Cassidy's death was the third self-inflicted death at Maghaberry Prison during 2018. Although the three men who died were located in different residential units and the circumstances of their deaths do not appear to be related, a number of shared learning points have emerged from my investigation of these deaths, which I will comment on in Section 4.

Section 2: Framework for this investigation

Mr Cassidy died at hospital as a consequence of injuries he sustained when he was found hanging in his cell at Maghaberry Prison. As his death resulted from events which occurred while he was in custody, I am required to investigate and report on the circumstances surrounding his death.

This investigation was conducted in line with my Terms of Reference and aims to provide explanations, where possible, to Mr Cassidy's family.

2.1 Questions raised by Mr Cassidy's family

Mr Cassidy's family raised a number of questions relevant to my investigation when they met with my predecessor. These are summarised below:

- What was the timeline of events leading to Mr Cassidy's death?
- Why was he committed to custody on 31 August 2018 and was this for his own safety?
- Had he been allowed to use the prison telephones while he was in custody?
- Had he self-harmed before his death as he had fresh cuts on his forearms?
- Why he was not released to what the family believed to be a suitable bail address prior to his death?
- Was the resuscitation effort adequate, as the family were advised by hospital staff that Mr Cassidy had been without oxygen for 1 hour and 45 minutes?
- Did Mr Cassidy receive treatment at least comparable to that which he would have received in the community?

2.2 Investigation methodology

My investigation methodology is designed to thoroughly explore and analyse all aspects of each case including any questions raised by bereaved relatives. The following information was gathered and analysed by my Investigating Officer:

- Prison Service records including Closed Circuit Television (CCTV) footage and telephone calls made by Mr Cassidy prior to his death;
- Interviews with prison and healthcare staff; and
- Healthcare records.

All of this information was carefully examined and I have detailed the relevant matters, which underpin my findings, in this report.

2.3 Independent advice

When appropriate, I commission an independent clinical review of specific aspects of healthcare. A clinical reviewer is commissioned from an agreed list, usually to provide a peer review of healthcare provision, and they provide a report with recommendations. My office provides relevant documentation and reviewers receive a Terms of Reference specific to each case. They provide an independent, expert opinion about care provided. A clinical reviewer may, for example, assess delivery of care in relation to current clinically approved guidelines, local and national. They will keep in mind whether or not care has equivalency with that provided in the community and any learning to improve care in the future.

I commissioned an independent clinical review of the healthcare provided to Mr Cassidy which was conducted by Professor Jenny Shaw. Professor Shaw is a Consultant Forensic Psychiatrist at Greater Manchester Mental Health Foundation Trust and a Professor of Forensic Psychiatry, University of Manchester. As a forensic psychiatrist she has particular experience of assessing and treating patients involved in the judicial process, and in the preparation of psychiatric reports.

Professor Shaw provided me with a report setting out her opinion on the matters she was asked to consider. I have included her opinion on relevant healthcare matters in my investigation report.

2.4 Scope and remit of the investigation

The specific objectives of this investigation were to establish:

- The circumstances leading up to Mr Cassidy being found unresponsive.
- If Mr Cassidy's healthcare needs were appropriately managed and if the care provided was at least equivalent to that he might have received in the community.
- If Mr Cassidy was appropriately managed on a SPAR and if the decision to close the SPAR on 01 December 2018 was appropriate.
- If the response to Mrs Cassidy's call on 05 December 2018 was appropriate and if it took account of a recommendation made in a published report concerning the death in custody of a [6]Mr O'Driscoll.
- If the response to the incident on 07 December 2018 was effective and specifically if the initial response from healthcare was timely.

[6] Report of the investigation into the death of Mr O'Driscoll, https://niprisonerombudsman.gov.uk/publications/death-in-custody

- If Mr Cassidy's death could have been predicted and if there were opportunities to prevent it.

A description of the key events leading up to Mr Cassidy's death are set out in Section 3 and my findings are set out Section 4.

Section 3: Description of key events

Committal and period in Bann House

Mr Cassidy was remanded to Maghaberry Prison on 31 August 2018 (a Friday). He had previously been remanded on the same charges during July 2018 and was released on bail on 03 August 2018. He had been held on remand for separate matters on one further occasion during 2017.

An initial and comprehensive healthcare assessment was conducted by a committal nurse (Nurse A) with Mr Cassidy following his committal to Maghaberry Prison. The initial assessment recorded details of daily drug overdosing due to daily harmful misuse of drugs and a suicide attempt. An opiate withdrawal assessment was initiated and his clinical observations taken. Information relating to the time Mr Cassidy spent in police custody was reviewed and the Electronic Care Record (ECR) assessed to check his current prescription for medication. The nurse recorded that Mr Cassidy had one Zopiclone[7] tablet in his possession when he arrived in prison custody. The second part of the healthcare assessment was conducted the following day by the same nurse when further details about Mr Cassidy's medical history were taken.

Mr Cassidy was accommodated in Bann House, the prison's committal unit.

On 03 September 2018[8] a mental health nurse (Nurse B) conducted an initial mental health screen. The mental health nurse referred Mr Cassidy for a routine mental health assessment but noted that should risk behaviours become apparent the assessment could be upgraded from routine to urgent[9]. On the same date prescriptions were produced for co-codamol and sertraline[10]. Mr Cassidy was assessed as not suitable to administer his own medication in accordance with the Trust's In Possession Risk Assessment Policy. This meant that Trust staff gave him his medication as required.

On the 05 September 2018 Mr Cassidy was called to attend an opiate withdrawal assessment which had been done each day since his committal. He did not attend

[7] Zoplicone is a medication used for the treatment of insomnia.
[8] The mental health screen is conducted the next working day after someone is committed. As the mental health team worked Monday-Friday at that time, this was the first opportunity to screen Mr Cassidy as he returned to Maghaberry Prison on a Friday. This screen entails a review of the ECR and information obtained during the initial and comprehensive healthcare assessment. It is not a face-to-face consultation.
[9] In line with referrals for mental health assessment in the community, the expectation is that a routine assessment should be conducted within nine weeks with urgent referrals being actioned within ten working days.
[10] Sertraline is a medication used for the treatment of depression.

this appointment and it was rescheduled for the following day. It is not clear why he did not attend this appointment.

Also on the 05 September 2018 Mr Cassidy had a visit from his partner – the first since his committal to prison. Mr Cassidy's partner visited him regularly, two to three times a week, during the first six weeks he was in prison and left money in for him.

On 06 September 2018 Mr Cassidy's withdrawal assessment score had reduced to four and he was discharged from further assessments as this score indicated he was no longer experiencing withdrawal symptoms.

Mr Cassidy was prescribed co-codamol tablets on 19 September 2018 by a prison doctor (Doctor A). This was to relieve pain associated with an injury from an earlier assault in the community.

On 20 September 2018 a report was submitted to the prison's security department that Mr Cassidy was believed to be in possession of drugs (Xanax[11]) following a visit.

The first SPAR

On the evening of 26 September 2018, a nurse (Nurse C) assessed Mr Cassidy as prison staff had reported that he had taken seven Xanax tablets and he appeared to be intoxicated. The nurse recorded that Mr Cassidy's speech was mildly slurred and that he was agitated. Mr Cassidy denied taking illicit substances. A SPAR was opened because Mr Cassidy had stated that he may not be able to keep himself safe. He was reportedly anxious about his partner. He was placed on 30 minute observations by prison staff and they were asked to complete four conversation checks. Later that night a nurse (Nurse D) checked on him and asked how he was. Mr Cassidy said he was '*sweet*' and refused to be assessed by the nurse. He saw a nurse the following morning and she found that he was sober, alert and clinically stable. He was issued with his regular medication.

After he saw the nurse, the Bann House Senior Officer (Senior Officer A) conducted a SPAR assessment interview[12]. During the interview Mr Cassidy said that he was depressed thinking about his father's death and he identified his vulnerability because of being away from his family and partner. He said that he did not want to self-harm but could not say that it would not happen again. An initial case review was held the following day. This was attended by a Senior Officer (Senior Officer B), a residential officer, a mental health nurse (Nurse E) and by Mr Cassidy. Mr Cassidy appeared in good form and said that he was feeling much better. He stated that he had no thoughts of suicide and self-harm. He cited his family as protective factors.

[11] Xanax is the trade name for a short acting benzodiazepine medication, Alprazolam, which is commonly used for the treatment of anxiety disorders. It is not prescribed in the United Kingdom.
[12] The purpose of the SPAR assessment interview is to gather pertinent risk information to inform the initial case review.

Everyone who attended the meeting agreed that the SPAR could be closed and Mr Cassidy was advised of support services.

A repeat prescription for Mr Cassidy's antidepressant medication was issued on 01 October 2018.

Roe House

Mr Cassidy transferred from Bann House to Roe House on 02 October 2018. He was doubled up with another prisoner.

A further prescription for co-codamol was issued on 03 October 2018 and a request made for a medication review.

A Roe House Senior Officer (Senior Officer C) held a SPAR post closure review[13] meeting with Mr Cassidy on 05 October 2018. During this discussion Mr Cassidy reported no thoughts of self-harm or suicide and that he was settling well into Roe House. He requested re-engagement with the prison's drug and alcohol support service, Alcohol and Drugs: Empowering People through Therapy (AD:EPT), as he had found this service beneficial in the past. The Senior Officer issued a referral to AD:EPT that day.

Mr Cassidy received an adverse report[14] on 08 October 2018 for misuse of his cell bell and became verbally abusive to an officer. The officer (Officer A) recorded that Mr Cassidy's behaviour was unacceptable and they gave him an adverse report.

A medication review was conducted on the same day by a prison doctor (Doctor B). The doctor reviewed Mr Cassidy's medical history and the use of the antidepressant medication he was taking. During this consultation Mr Cassidy reported he was abused as a child and heard voices and the doctor recorded a history of self-harm. Mr Cassidy reported that he continued to suffer pain following an assault and they discussed a plan to commence a different neuropathic pain relief medication (amitriptyline) and gradually reduce the use of co-codamol. A repeat prescription was generated for co-codamol on 12 October 2018. The doctor highlighted that the plan was to reduce this medication in line with the review he had conducted a few

[13] A SPAR post closure review is conducted within seven days of a SPAR being closed and is an opportunity to check what progress an individual, if any further support is required and if actions identified in care plans have been followed up.
[14] Adverse reports are issued by staff in response to behaviour which falls below that expected under the Prison Service Progressive Regimes and Earned Privileges Scheme (PREPS). Three adverse reports within a reporting period will result in consideration of a demotion in regime. Staff record the adverse reports on a staff contribution form and are required to notify the prisoner that a report has been given and request their signature to acknowledge they have been informed about the report or record that they refused to sign the document.

days earlier. Further prescriptions for co-codamol were issued on 20 October 2018 and 25 October 2018.

The day after receiving the first adverse report, the same officer (Officer A) gave Mr Cassidy a second adverse report after he was observed smoking in the recreation room.

On 13 October 2018 Mr Cassidy's partner was due to visit him but did not attend the visit. This was the first visit she had not attended since Mr Cassidy's committal to prison at the end of August 2018. One further visit was not attended during October 2018 but six further visits were attended between then and early November 2018.

A resettlement needs profile was completed on 16 October 2018 and two days later an officer (Officer B) completed a PREPS report in which it was recorded that Mr Cassidy interacted well with other inmates but had been argumentative and aggressive towards prison staff. Officer B referenced the two recent adverse reports and that Mr Cassidy did not attend any constructive activities. The officer recommended that Mr Cassidy remain on standard regime but that if he received another adverse report then he would be placed on the basic regime which would result in a loss of privileges.

On 30 October 2018 a repeat prescription was issued for amitriptyline and sertraline. The following day a nurse (Nurse F) saw Mr Cassidy. He said he could not cope with the reduction in co-codamol and reported that he was in pain all over. The nurse sent a request to the doctor and the dose of both medications was increased the following day. The doctor indicated the plan was still to reduce and then stop the prescription for co-codamol.

On 01 November 2018 Mr Cassidy again attended the treatment room and saw a nurse (Nurse F). He requested to see a prison psychiatrist as he felt depressed and anxious. The Nurse offered a general practitioner (GP) appointment but Mr Cassidy refused this and said that he wanted to see a psychiatrist. He told the nurse he was engaged with mental health services in the community. The nurse asked Mr Cassidy if he had thoughts of self-harm or suicide and noted that he appeared very anxious. After the consultation the nurse sent a referral to the prison's mental health department which was reviewed the following day. It was noted that Mr Cassidy was already awaiting a routine mental healthcare assessment, from his first referral on 03 September 2018. As Mr Cassidy stated he had no current thoughts of self-harm or suicide, no requirement for a SPAR was identified and the referral for a mental health assessment was not upgraded to urgent.

A search of Mr Cassidy's cell was conducted on 03 November 2018 and nothing was found. On 04 November 2018 Mr Cassidy asked to see a nurse (Nurse G) during night shift and reported a medical problem. A nurse saw Mr Cassidy and said they would ask a colleague to review him in the morning and he thanked the nurse.

Just before lunchtime on 05 November 2018 Mr Cassidy became verbally abusive to a nurse (Nurse H) when his medication was being administered. The nurse had called him to the treatment room to discuss the problem he had raised with their colleague during the previous night shift. The nurse recorded that Mr Cassidy had been extremely hostile, and when he was leaving the treatment room, he said that he was away to slit his throat. The nurse contacted the House Senior Officer (Acting Senior Officer D) and they went to Mr Cassidy's cell to speak to him. Mr Cassidy told the nurse and Senior Officer that he was very agitated due to an earlier video-link appointment. He apologised for his behaviour and assured them that he could keep himself safe. The nurse recorded that Mr Cassidy seemed preoccupied with medication at that time and that he had been informed that a GP appointment had been made for him. A SPAR was not opened on this occasion.

Mr Cassidy received a further adverse report in relation to his behaviour towards the nurse.

AD:EPT conducted a 'check-in' appointment with Mr Cassidy on 06 November 2018 and confirmed with him that he was on the waiting list for assessment. This related to the referral generated at the post closure review meeting on 05 October 2018.

On 08 November 2018 Mr Cassidy attended a visit with his partner.

On 09 November 2018 a report was submitted to security that medication had been found in Mr Cassidy's cell. The label indicated it was supervised swallow medication for that evening. Although the Trust had provided guidance to the Prison Service in relation to the deployment of a standard operating procedure for the administration of medication under exceptional circumstances, residential staff appeared to be unaware of a change to the way medication was being administered.

On the same day Mr Cassidy received treatment for injuries, having allegedly been assaulted by another prisoner. Mr Cassidy was treated, initially in the treatment room and then later at hospital, for injuries to his face. While he was being examined in the treatment room he became drowsy and a nurse recorded that he seemed heavily under the influence. Observations were maintained until an ambulance arrived. Paramedics administered naloxone, a drug used to reverse the effects of opiates, with no effect. Mr Cassidy was taken to outside hospital for further treatment. However, Mr Cassidy was brought back to prison from hospital later that night and a nurse (Nurse I) checked on him. He told the nurse that the hospital had put paper stitches on the bridge of his nose and that he was feeling fine.

On 10 November 2018 Mr Cassidy went to the visit hall for a visit scheduled with his partner, but Mr Cassidy returned to Roe House without having had the visit.

The second SPAR

Shortly after he returned to Roe House that afternoon, Mr Cassidy self-harmed and a SPAR was opened. He told the House Senior Officer (Senior Officer C) that he had cut his right arm because no-one was listening to him. The Senior Officer suspected Mr Cassidy was under the influence of some substance although he denied this. Mr Cassidy said he was upset that he did not get to see his partner that afternoon and expressed frustration at the prison regime and how this had impacted on his visit. An immediate action plan was put in place which required Mr Cassidy to be monitored at 30 minute intervals and a nurse (Nurse H) treated the cuts he had made to his arm. Mr Cassidy told the nurse that he had swallowed a razor blade and he may cut himself further. The nurse recorded that Mr Cassidy had stated he cut for release.

During a search of Mr Cassidy's cell on the same date two bongs[15] were found.

Following a review on 12 November 2018, during which Mr Cassidy said he could not remember what had happened on 09 November 2018 when he was allegedly assaulted, all agreed that the SPAR could be closed as he was now feeling good.

Events to 29 November 2018

Mr Cassidy saw his Personal Development Coordinator on 13 November 2018 and again reported he did not know why he had been assaulted. No further issues were noted.

A repeat prescription for amitriptyline was issued on 13 November 2018 and the doctor flagged it was to be taken under supervision only.

Two days later Mr Cassidy failed a routine mandatory drug test. The sample tested positive for a cannabis metabolite. He was subsequently charged under Prison Rules.

A mental health nurse (Nurse B) conducted a full mental health assessment on 16 November 2018 although due to work pressures the notes were not written up until four days later. This was the assessment arising from the mental health screen conducted approximately ten weeks earlier (03 September 2018). The outcome of the assessment was that Mr Cassidy was to be discussed at the Mental Health Multi-Disciplinary Team Meeting (MHMDTM). This MHMDTM took place on 20 November 2018 and it was decided that there was no requirement for Mr Cassidy to be added to the mental health team caseload and he was discharged from their caseload. However he remained in the mental health prison system as it was noted he was currently engaged with AD:EPT (although up to that point had taken part in one check in appointment and was awaiting assessment) and a referral was made to a managing stress programme.

[15] A bong is a filtration device generally used for smoking cannabis.

Between 16 November 2018 and 20 November 2018 Mr Cassidy submitted four requests: two related to emergency phone credit – one of which was granted, one was a request to see his sentence manager which was closed as he was asked to provide more details and the fourth resulted in his name being added to the waiting list for Alcoholics Anonymous (AA) meetings. An appointment was made for Mr Cassidy to attend an AA meeting later in the month but he declined to attend.

Mr Cassidy received a visit on 22 November 2018 from his partner. This was the last visit his partner attended prior to Mr Cassidy's death.

On the same date he attended a video-link appointment. He was also demoted to basic regime and submitted a request in respect of a PREPS demotion appeal. In his request form Mr Cassidy stated he was only aware of receiving one adverse report for smoking in the recreation room. The request was sent to the House Senior Officer (Senior Officer D) who asked to be given details of the three adverse reports. These were provided and the Senior Officer referred the matter to a residential Governor (Governor A). The Governor asked for evidence that Mr Cassidy had received details of the adverse reports i.e. if he had signed acknowledgement of receipt of these or refused to sign them. This was returned to landing staff for comment but had not been addressed at the time of Mr Cassidy's death when he continued to be on basic regime.

On 26 November 2018 a repeat prescription was issued for Mr Cassidy's antidepressant medication.

Mr Cassidy made two telephone calls to his partner on 28 November 2018. In the first he expressed frustration that she could not attend a visit earlier that morning. In the second call she assured him she would visit the following morning.

The third SPAR

On the 29 November 2018 Mr Cassidy was scheduled to have a morning visit. He spoke to his partner on four occasions that morning. They initially talked about a bail application and forthcoming court dates but in the last call they had a row when he discovered she had nothing to bring him when she visited. He talked about owing people stuff until she was able to visit. He then attended a video-link hearing and was granted bail subject to certain bail conditions being satisfied. One condition was that he resided at an address approved by the police. He was not able to find a suitable address in the period before his death.

He later attended the morning visit session but returned to Roe House a short time later as the visit did not take place. He self-harmed by making what the nurse described as multiple superficial cuts to his left arm. A SPAR was opened by the House Senior Officer (Senior Officer C). Mr Cassidy stated he had self-harmed because of news he had received during his video-link hearing and also said his

mood was low as he was anxious about the hospitalisation of a relative. A call had been received by an officer on the landing earlier and Mr Cassidy was told that a visit scheduled for the afternoon would not be taking place because someone had been taken to hospital. It was not clear who. It appeared Mr Cassidy harmed himself shortly after receiving this news.

Mr Cassidy was allowed to make a phone call to clarify the situation and he phoned his partner. He was angry with her for not attending the visit earlier in the day and she explained why. He told her his head was fried because she had been making visits and cancelling them. He told her that he had cut himself and also alleged that an officer had dared him to do it. He spoke to his partner on two further occasions that afternoon. On several occasions she asked him not to do anything stupid. The last call ended with them on better terms.

An assessment interview was conducted by the House Senior Officer (Senior Officer C) on 30 November 2018. The Senior Officer noted that Mr Cassidy said he self-harmed because his mother had been taken to hospital and he was unsure what was going on. He told Senior Officer C he had cut himself to relieve stress and gave an assurance that he was not thinking of suicide. He expressed regret at injuring himself and he said he wanted to learn how to deal with his stress and anxieties in a different way.

Mr Cassidy spoke to his partner on two occasions that day. He did not speak to her again until 06 December 2018. In the interim he telephoned his mother and a family friend because he could not get in touch with his partner directly. Both assured him that they would make efforts to contact her.

On 01 December 2018 Mr Cassidy received another adverse report for having a television in his cell. As he was on the basic regime, he was not entitled to a television.

On the same date an initial SPAR case review was conducted. It was chaired by a Senior Officer from the PSST (Senior Officer E) and was attended by Mr Cassidy, the House Senior Officer (Senior Officer D) and a residential officer (Officer A). A nurse (Nurse J) provided information to the meeting following a conversation with Mr Cassidy. All agreed that the SPAR should be closed and one action point was identified for the House Senior Officer to contact Mr Cassidy's partner as he had no phone credit. Again it was noted that the act of self-harm was impulsive, there was no real intent to end life and that Mr Cassidy was now settled and was about to attend a visit. The Senior Officer telephoned Mr Cassidy's partner.

Mr Cassidy attended a visiting session but returned to the House when the visit did not go ahead.

Mr Cassidy wrote a letter to his partner dated 02 December 2018 but this was not sent. In it he stated that he missed her and did not know what was going on. He referred to his head doing overtime and that he was ready to throw the rope up. There was another handwritten note written on a visit booking reference form which said, '*Made me sit like a fool again ffs lol*'.

On 02 December 2018 Mr Cassidy spoke to his mum and asked her to tell his partner to book a visit. He told his mother that he had been granted bail and needed an address.

The following day Mr Cassidy attended an AA meeting and he met with AD:EPT to complete an assessment – this was in response to the referral submitted on 05 October 2018. He also submitted a further request for emergency phone credit to contact his mother. He said he had not talked to his family since the previous Thursday. He was given emergency phone credit and he again telephoned his mother who told him that his partner had booked a visit for the following Tuesday. At the end of the call he told his mother he was '*100%'* after she asked how he was.

On 04 December 2018 a consultant Forensic Psychiatrist (Doctor C) reviewed the patient records received from the Western Health and Social Care Trust. These had been requested following the MHMDTM on 20 November. At that MHMDTM Mr Cassidy was discharged from the mental health team caseload on the basis that there were no current risk behaviours. Following Doctor C's review of the records received this position remained unchanged.

Just before 16:00 on Wednesday 05 December 2018, Mr Cassidy again telephoned his mother and asked if she had heard anything from his partner as she had not attended a further visit. Mr Cassidy's mother asked him if he was okay. He replied that he was not and that his head was fried, he had no money and he had had no recent visits. Mr Cassidy's mother assured him that she would try to contact his partner. After he came off the phone to his mother, he also telephoned a friend and enquired after his partner.

At 21:30 that evening Mr Cassidy's mother telephoned the prison and raised concerns about her son's mental health and stated she was worried about him self-harming. The call was taken by a night custody officer (Officer C) in the prison's emergency control room. Officer C recorded the details in a Safer Custody log which documents calls from concerned relatives and also relayed Mrs Cassidy's concerns to the night shift Senior Officer (Senior Officer F). As the night shift Senior Officer was already on their way to carry out checks and supervise medication being issued in Roe House, they decided to check in on Mr Cassidy while they was there. When Officer C entered the House, they spoke to the night custody officers who told them that Mr Cassidy had recently been on a SPAR. Officer C went to Mr Cassidy's cell, unlocked it and entered the cell and spoke to Mr Cassidy. After their conversation, the Senior Officer said they had no concerns about Mr Cassidy, they relocked the cell

and continued with their duties. All remaining checks were completed during the night in accordance with Maghaberry Prison's Governors' Orders. No further incidents were reported about Mr Cassidy that evening.

On 06 December 2018 Mr Cassidy requested to again speak to someone about housing and his request was submitted to the prison's Prisoner Development Unit. Mr Cassidy had attended an earlier appointment during November when he had previously discussed his housing options.

Mr Cassidy also spoke to his partner by telephone and in the course of that call he told her that his head was fried and that the night before he had felt like putting the rope up. His partner confirmed she planned to visit him the following day.

Events on 07 December 2018

At 09:33 on 07 December 2018, a Senior Officer (Senior Officer D) conducted the SPAR post closure review following the closure of the SPAR on 01 December 2018. This discussion involved the Senior Officer and Mr Cassidy. The Senior Officer was content that Mr Cassidy was much more settled, by his own admission, and that the crisis had passed. He told the Senior Officer that his mum was recovering well. He said that he had completed an education form and was waiting for a class to be provided. He asked the Senior Officer to refer him to programmes conducted in the wellbeing hub (known as the Donard Centre) as he felt these would benefit him. They agreed that a referral to AD:EPT was not required as he had already been referred to this service. The Senior Officer noted in their record of the meeting that Mr Cassidy was fully aware of the support mechanisms available in the prison but had no requirement of them. A request for Mr Cassidy to attend the Donard Centre was submitted after his discussion with the Senior Officer.

The Senior Officer who conducted the post closure review meeting recalled that Mr Cassidy was '*buzzing*' that morning about having a visit and was keen to get his clothes sorted and himself ready for the visit. Senior Officer D saw Mr Cassidy from their Office when he returned from visits but the exchange between them at that point related to whether or not the Senior Officer had referred him to the Donard Centre

Three days' worth of medication was given to Mr Cassidy by Trust staff. A nurse (Nurse H), who was later involved in resuscitating Mr Cassidy, noted that the medication packages issued that morning were all empty. This amounted to 60mg of amitriptyline and 300mg of sertraline.

A further PREPS report was completed that morning and concluded that Mr Cassidy should remain on basic regime.

At 15:15 Mr Cassidy left Roe House to attend his afternoon visiting session. He returned to the landing and was locked in his cell just before 16:00. Shortly after this a prisoner (Prisoner A) stopped at Mr Cassidy's cell, opened the flap and spoke to him. The prisoner said that Mr Cassidy told him that he had not had a good visit because his partner had not been let into the prison again. The prisoner said he asked Mr Cassidy if he was okay and he nodded his head. This was the last interaction anyone had with Mr Cassidy.

Roe House was locked at 16:35 and the roll call was returned as correct at 16:46. Evening routine on the landing commenced at 17:00.

At 17:06 an officer (Officer D) walked past Mr Cassidy's cell to unlock orderlies to serve the tea meal. At 17:09 their colleague (Officer E) began unlocking prisoners to collect their tea meal. At 17:11 Officer E looked into Mr Cassidy's cell and immediately locked two prisoners who were walking towards them. Officer E ran to the class office desk on the landing and activated the discipline alarm and called to their colleague on the landing (Officer D) and they both ran to Mr Cassidy's cell door. They pushed the cell door and gained access to the cell 40 seconds after the officer first looked in the cell door. They cut the ligature, lowered Mr Cassidy onto the floor and immediately commenced cardiopulmonary resuscitation (CPR) in the cell. By this time staff had responded from other landings in Roe House and assisted with CPR. A defibrillator was available. It was applied but at no time did it advise that a shock should be given. The House Senior Officer (Senior Officer C) also attended the scene and transmitted an urgent radio message to request the attendance of Trust staff. They sent a Code Blue[16] message approximately 90 seconds later when they established that Mr Cassidy had been found hanging and was unresponsive.

The first nurse (Nurse C) arrived on the landing at 17:18 and was joined by colleagues shortly afterwards. They performed immediate life support measures and were assisted by Prison Service staff to rotate chest compressions until the arrival of the paramedics just before 17:40. The ambulance left Roe House at 18:17 and brought Mr Cassidy to hospital.

A hot debrief[17] meeting was conducted at 18:25 and was chaired by the Duty Governor (Governor B). It was attended by the majority of staff who were directly involved in resuscitating Mr Cassidy, including nurses, and the Deputy Governor.

[16] Maghaberry Prison's Governors' Order 1-26 (April 2018) defines a Code Blue as respiratory distress, unconscious, severe chest pains etc.

[17] Standard 25 of the Northern Ireland Prison Service (NIPS) Suicide and Self Harm Prevention Policy 2011 (updated 2013) states that hot and cold debriefs must take place following a serious incident of self-harm or death in custody. The hot debrief should take place as soon after the incident as possible and involve all the staff, where possible, who were closely involved with the incident. The purpose is to provide staff with an opportunity to express their views in relation to how the situation was discovered and managed, and any additional support or learning that could have assisted.

Due to the seriousness of the incident the Duty Governor (Governor B) and Deputy Governor (Governor C) decided that Mr Cassidy's designated next of kin, should be contacted immediately and attempts were made to contact them. At 18:47 Prison Service staff, who were escorting Mr Cassidy, informed Maghaberry Prison's emergency control room that medical staff had requested that Mr Cassidy's family be contacted. Efforts continued to contact Mr Cassidy's designated next of kin but were unsuccessful and the prison asked the police to assist. At 22:05, police advised Maghaberry Prison's emergency control room that they had called with the designated next of kin but got no response. At 23:06 Mr Cassidy's mother telephoned the prison and requested confirmation of an incident involving her son. She spoke to the Night Manager (Senior Officer G).

Mr Cassidy continued to receive treatment at hospital until his death on 11 December 2018. A post mortem was conducted and the cause of death was recorded as 'hypoxic ischaemic necrosis of the brain, pneumonia, pulmonary thromboemboli and myocardial necrosis due to hanging.' Analysis of a blood sample indicated the presence of Mr Cassidy's prescribed medications at therapeutic levels and also detected the suggested use of or recent exposure to cannabis. As this substance can remain in the blood for several days the pathologist stated that its presence does not confirm that Mr Cassidy was under the influence of cannabis at that time. An inquest is pending.

The cold debrief[18] meeting took place on 19 December 2018 and was chaired by the prison's Head of Operations (Governor D). Attendees comprised some of the first responders but not the two officers who found Mr Cassidy and several of the nurses who responded to the incident.

[18] The cold debrief is expected to take place within 14 days of the incident and aims to provide further opportunity for staff to reflect on events and identify any additional learning. This also provides a further opportunity to check in with staff involved in an incident.

Section 4: Findings

This section sets out my findings under each investigation objective.

4.1 Establish the circumstances leading up to Mr Cassidy being found unresponsive.

I have set out the events and circumstances leading up to the point Mr Cassidy was found in Section 3.

This should provide some insight for Mr Cassidy's family and others about Mr Cassidy's journey from the day he was committed to Maghaberry Prison until he was taken to hospital.

I listed in Section 2.1 the questions that the family asked me to address during the course of my investigation. Answers to these questions are given in Section 3 and I have summarised them below:

- Mr Cassidy's bail was revoked and he returned to custody.
- He had self-harmed on two occasions during November. On 10 November 2018 a nurse treated cuts to Mr Cassidy's right arm which he had made with a razor blade. He also received treatment for cuts on his left arm on 29 November 2018. The post mortem report stated there were 'multiple linear scars and healing wounds to the right upper limb consistent with previous episodes of self-harm using an instrument with a sharp edge.'
- Mr Cassidy's use of the prison telephones was likely reduced because he had very little money in his account. Access to the phone was restricted to times when the landing was unlocked. He was given emergency phone credit on a number of occasions and was given additional access after one self-harm incident.
- He was not released on bail because a suitable address had not been given to and approved by the police.

4.2 Were Mr Cassidy's healthcare needs appropriately managed and was the care provided at least equivalent to that he might have received in the community?

Risk factors, policies and procedures

As referenced in the foreword, Mr Cassidy had risk factors which may be described as sub-diagnostic. I am of the view that these factors, if gathered and assessed, would provide helpful information for the management of prisoners with complex needs. This would require significant effort in terms of gathering information from a variety of sources, analysing the information for risks and themes, and applying individualised strategies to address the implications of low-level, persistent risks which, taken together, increase risk. Each decision about an individual would, therefore, be informed by a wide lens view of history and care to provide the case formulation and management approach that I have referenced in a number of reports and which clinical reviewers have brought to my attention on a number of occasions. This approach would also engage a prisoner in their own care.

There is no doubt that, however valuable such an approach, it would require both a mind-set shift and significant resource investment to accommodate and deliver. Currently the resourcing and mechanisms do not exist for different recording systems to share information with one another nor for staff to give the attention this would require.

As things stand, the delivery of existing policies and procedures are critical to the care of individuals and these must be adhered to. At the same time, where improvement is considered the raft of sub-diagnostic risk factors should be kept in mind.

Initial assessments

Nurses did their initial and comprehensive healthcare assessments within expected timeframes. Medication was checked against ECR and prescribed. As a result of the mental health screening process, Mr Cassidy was referred for a routine assessment. This was done within ten weeks of him coming back into prison. The average time for routine

RISK FACTORS

Bereavement

Isolation

Addiction

Basic regime

Access to his children

Self-harm and previous suicide attempts

No constructive activity

No bail address

Physical pain

Poor coping strategies

Adverse reports

Reducing number of visits

Very little money

Paramilitary threat

Abuse

Use of illicit drugs in custody

assessments is nine weeks and this compares well with community referrals.

Professor Shaw said that the process whereby all prisoners are screened by a mental health nurse was good and the triage system was sensible.

Mental health assessment and discharge from the prison's mental health service

Mr Cassidy's community mental health records were requested on 20 November 2018 (three months after committal) and were reviewed by a Forensic Psychiatrist on 04 December 2018. This was after Mr Cassidy had been discharged from the prison's mental health team.

Professor Shaw said that these records should have been requested when Mr Cassidy first came into prison so that they could be used to inform the mental health assessment.

Professor Shaw also said that Mr Cassidy should not have been discharged without the community records being reviewed, however, on balance it was unlikely that Mr Cassidy would have met the criteria for ongoing management on the secondary care caseload.

Recommendation 1
Community records: I recommend to the Head of Healthcare that community records should be reviewed before a patient is discharged from the mental health team caseload.

The Trust acknowledged that patient notes are not always received in a timely manner and to wait for records before discharging patients could result in patients being held unnecessarily on a caseload or they could be released from custody before previous records arrive. The Trust pointed to regional processes to improve information flow between services including a new protocol for the transfer of mental patients between Trusts (August 2019) and the commissioning of a new regional IT project (Encompass) to allow electronic information sharing within and between services. The Trust further stated that its own staff do correspond with staff in other Trusts to ensure the smooth transfer of mental health records.

Professor Shaw acknowledged that the Trust is taking forward work to develop mental health provision in line with National Institute for Health and Care Excellence (NICE) National Guideline 66. This included better information exchange with community mental health services and she welcomed these developments.

The timely transfer of records is an issue that has been raised in other death in custody recommendations. I will keep the developments the Trust referred to under review.

Medication

At committal Mr Cassidy was assessed as not suitable to take his own medication.

When prisoners cannot be given their own medication to take, it is given to them by nurses. This means when prisoners are locked in their cells, for example at night, nurses must go from cell to cell to dispense medication. Before Christmas 2018, staffing levels in Maghaberry Prison were low and the Trust looked again at who could safely be given a short supply of their medication. To do this the Trust carried out a general risk assessment. Mr Cassidy, was issued with a 'once only' dose of medication for the weekend (which in his case comprised of medication for three days) in accordance with the Trust's standard operating procedure for administering medication under exceptional circumstances.

Professor Shaw saw no detailed rationale in the records to support the decision to issue Mr Cassidy with a three day supply of his medication and deemed this reversal without rationale to be unacceptable. With regard to his amitriptyline, the Professor Shaw set out how overdose could have negative cardiac implications. However she was satisfied that with the likelihood of Mr Cassidy taking all his medication at once, the risk would have been low. In the same way the low dosage would not have been likely to have caused suicidal behaviours. With regard to his sertraline, Professor Shaw observed that taking all three days medication at one time while over the normal daily dosage would most usually cause drowsiness or euphoria. As above, the dosage would have been unlikely to contribute to increased suicidal ideation. Overall, therefore, Professor Shaw concluded that the amount of medication taken by Mr Cassidy did not significantly contribute to his death. Her greater concern was the lack of rationale for the change from supervised swallow to in-possession medication. I concur with her findings.

Doctor B conducted a medication review on 08 October 2018 and discussed Mr Cassidy's antidepressant medication. Professor Shaw looked at the notes made by the Doctor and did not consider it be a full review of the need for antidepressants. Professor Shaw noted that the Doctor recorded that Mr Cassidy had no side-effects but did not go into sufficient detail about the symptoms of Mr Cassidy's depression to establish whether or not the medication was still needed. Professor Shaw said she did not see evidence for the rationale to continue or not to continue with Mr Cassidy's antidepressant medication. In Professor Shaw's view anyone coming into prison on an antidepressant should have this reviewed to establish whether it is still required.

The Trust highlighted that the use of antidepressant medication is reviewed at the initial and comprehensive healthcare assessments and that pharmacy staff and GPs work collaboratively to achieve concordance.

Case formulation and management

Mr Cassidy's family reported mental health and serious addiction problems which had worsened following the death of Mr Cassidy's father in 2015. They also advised that he had received death threats and it was their belief that a number of unhealthy relationships had sparked a decline in his mental health.

Prison officers who managed Mr Cassidy in Roe House Landing 2 reported very limited knowledge of Mr Cassidy's background and underlying risk factors.

Telephone calls made by Mr Cassidy provided insights to relationship anxieties and potentially ongoing drug use.

Professor Shaw said that it was possible to piece together a picture of Mr Cassidy from the documents she had read but nowhere in his prison medical records was this drawn together, his needs formulated and a management plan set out for Trust and Prison Service staff to follow.

Having looked at all the information provided in this case Professor Shaw said it was evident that information was available to some people and not others and that knowledge of the whole picture would have assisted risk assessment and management. She said this is very common in prisons across the United Kingdom with different professionals working in silos.

Professor Shaw emphasised that Maghaberry Prison is not alone in experiencing difficulties with the management of people like Mr Cassidy with '*complex, sub-diagnostic*' needs.

Mr Cassidy had multiple lower level vulnerabilities and there needed to be an understanding of how all of these mental health, substance misuse and learning difficulties fitted together. In her experience this was a group of people that prisons do not get to grips with very well.

Ideally, she said, prisons should provide more trauma/psychologically informed care. She felt there was some learning from Psychologically Informed Planned Environments (PIPEs) she had visited in England may be helpful but acknowledged it was resource intensive. She suggested that some of the principles underlying this approach and those used to address the needs of children and young people in secure facilities could be examined and adopted in NI prisons.

Psychologically Informed Planned Environments focus are specifically designed environments which aim to create a safe and supportive environment. Staff working in these units are trained to have an increased psychological understanding of their work. There is a large focus on staff to prisoner interactions and prisoners benefit from a person centred approach and are given formal and structured report.

I agree with Professor Shaw that it is important for the Prison Service and the Trust to consider how best to meet the needs of people like Mr Cassidy when they come into prison and indeed when they move between prison and the community.

One of the issues this case highlights is isolated decision making and silo thinking and working. Each of the individual incidents involving Mr Cassidy whether a visit not attended, a failed drug test, an adverse report, or dissatisfaction with his medication may not of themselves have given cause for concern but when taken together give a better picture of his life and experience at that time. Indeed it gives some insight into the mental turmoil and emotional pain he was likely experiencing. It seemed to me that Mr Cassidy was asking for help in all sorts of ways but no-one could hear him because there was not an appropriate diagnostic pathway to define his needs and respond.

This was the third death in custody I investigated in 2018 and two others followed in that year, a total of 5 have now been identified, where the need for a case formulation and management plan has been proposed as a way of supporting those with multiple complex problems but who fall short of meeting the criteria for secondary mental health care. An important consideration of this approach is proportionate information sharing between Prison Service and Trust staff so that all are working to the one plan.

The Department of Justice has noted the reference made in respect of case formulation and management and, has committed to working with colleagues in the Department of Health and others to examine if a new model of working which draws on this approach can be developed and tested for those with multiple, lower level problems who spend relatively short periods in custody and community. The Department will provide me with regular updates on the progress of this work.

I had made a further request for work such as this to be completed following a meeting with the Director, Reducing Offending and representatives of the Trust who provide prison healthcare services. In that request, 19 August 2020, I had raised concerns about adequate information being shared between community and prison care and between services working within prisons to ensure that prisoners received the best possible healthcare. My request was specifically that alternative models of care arising from current death in custody investigations be examined, Mr Cassidy's being one of these.

RQIA's review of how vulnerable prisoners are cared for goes some way to addressing concerns I have frequently raised regarding prisoner needs and my request to the Department. I will work closely with RQIA to ensure issues of concern continue to be brought to their attention and to the commissioning body for healthcare in prisons.

4.3 Was Mr Cassidy appropriately managed on SPAR and was the decision to close the SPAR on 01 December 2018 appropriate?

Three SPARS were opened on Mr Cassidy during his last period of custody. The arrangements have now evolved but at the time Mr Cassidy was managed under the processes set out in the Prison Service Suicide and Self Harm Prevention Policy 2011 (updated 2013).

Technically all SPAR checks were done and reviews completed within the specified timescales and involving the relevant people. However, I make a number of observations from an examination of the three SPARs:

- Each SPAR appeared to be treated as an isolated event or incident.
- Prison staff reported limited knowledge about Mr Cassidy generally and no insight into the reasons Mr Cassidy self-harmed and the possible triggers and risk factors associated with this behaviour.
- SPAR observation records were not in-depth.
- There appeared to be a reliance on Mr Cassidy reporting that he could keep himself safe or of his account of why he had self-harmed when what he said in telephone calls was different.
- There seemed to be an acceptance that Mr Cassidy cut for release.
- There was no significant follow up to potential stressors such as a reducing the number of visits and telephone calls.
- The Senior Officer who did the post closure review on 07 December 2018 had not been told that Mrs Cassidy had called the prison about her son so had no opportunity to explore this.

Professor Shaw's opinion was that the entries in all parts of the SPAR were superficial. She found no proper explanation of what the self-harm meant in the context of a person's mental health and life events. She said that there needed to be a greater emphasis placed on the importance of a thorough assessment and understanding of the self-harm incident in the context of a person's longitudinal history, risk factors and triggers. She also identified a need for staff conducting observations to have meaningful conversations with the prisoner.

Residential Officers have an important role to play in gathering intelligence about an individual's wellbeing from their interaction with other prisoners and through getting to know them and their life experiences. It is this knowledge that often alerts them to concerns about individual prisoners and it is this type of observation and information that should feature in the assessment of a person's risk factors and triggers.

Colleagues from the Trust and the Prison Service developed SPAR Evolution, a new people-centred model, which was signed off on 05 April 2019. The new operational

procedures and a new IT solution incorporating mobile technology which meant staff were more informed about individuals in their care was rolled out in stages across all prison sites completing in August 2020.

While the new SPAR Evo has yet to be evaluated the shift in emphasis is obvious. This is a significant and important development for supporting prisoners. The encouragement to engage directly with the individual who is potentially at risk is also significant and can contribute to increased trust. However, without evaluation the full extent of the improvement is unknown. I endorse the RQIA recommendation for an external review of the SPAR Evo approach and emphasise the urgency of this evaluation being completed. I suggest that matters relating to training and refresher training appropriate for utilising SPAR Evo, including how, when and by whom a Concern Form is opened, should be covered in that review and I endorse it be initiated without delay.

4.4 Was the response to Mrs Cassidy's call on 05 December 2018 appropriate and did it take account of a recommendation made in a published report concerning the death in custody of a Mr O'Driscoll

The Prison Service response to calls from concerned relatives has been raised in other death in custody investigation reports. In a report, published in April 2018, relating to a Mr O'Driscoll, the Ombudsman found that the Prison Service had learned lessons and changed its practice to an extent. However, in that case, due to shortcomings in how the Prison Service handled a call from a concerned relative, the Ombudsman made a further recommendation which was accepted in November 2017. The recommendation was:

"The Prison Service should issue guidance for staff on how to respond to calls from concerned relatives. This should include consideration of:

- The prisoner's custodial history and any recent/previous incidents of self-harm;
- Listening to a recording of any call made by a prisoner where they have threatened to take their life;
- Speaking directly to the prisoner;
- Consulting with healthcare staff; and
- Comprehensively documenting and sharing the actions taken by all staff involved to safeguard the prisoner."

As both mothers made the prison aware of concerns they had for their son's welfare, I want to be satisfied that the lessons from Mr O'Driscoll's case have been learned.

Mr Cassidy's case was different because:

- the staff were aware that Mr Cassidy had recently been on a SPAR;

- the night shift Senior Officer checked Mr Cassidy himself shortly after his mother had telephoned the prison but they did not tell him that his mother had called. It is unusual for prisoners to be unlocked at night unless for medication or some other exceptional reason. The fact that the Senior Officer entered the cell and had a conversation with Mr Cassidy was good.

In a telephone call with his partner the day after his mum spoke to the prison, Mr Cassidy told his partner he had felt like putting the rope up the night before. It's possible that the night shift Senior Officer's intervention made a difference.

The issue in this case was that no record was made of what action was taken in response to Mrs Cassidy's call and the Senior Officer who did the post closure review, two days later, and the officers on Mr Cassidy's landing, did not know that Mrs Cassidy's had told the prison about her concerns for her son.

The night shift Senior Officer said they likely did not make a record in their journal because they were satisfied that they had properly addressed the concern raised by Mrs Cassidy. With hindsight they would have made a record of what action they took that night. Even if they had made a record either in their journal or the night manager's report, it is unlikely, given what they would have recorded, that the record would have precipitated any further action or that this information would have been passed on to the Roe House Senior Officer and the landing staff. On learning of what had happened, the night shift Senior Officer submitted a communication sheet explaining how they responded to Mrs Cassidy's call. One housekeeping point is that the identity of the person who took the call in the emergency control room is not recorded on the Safer Custody log. This would be helpful should anyone later need to speak to that person.

Issues with recordkeeping has been a recurring theme arising from death in custody investigations. I appreciate that staff have many demands on them, often competing and arriving unexpectedly. This is less about recordkeeping and more about creating a culture in which the importance of recordkeeping is understood as a matter of safety. I again underline to the Prison Service the importance of making timely records of all relevant information in journals or other reports/systems.

Professor Shaw said that:

- Mrs Cassidy's concerns should have been discussed directly with Mr Cassidy.
- They should also have been fed into the post closure review.
- If necessary concerns from relatives should be passed to the Trust (may not have been appropriate in this case).
- The Prison Service should have clear mechanisms for this information to be passed to relevant groups within the prison.

I fully endorse this recommendation. There are a number of ways in which the concerns raised by Mrs Cassidy may now be handled differently because of procedures which were introduced after Mr Cassidy died:

- The Prison Service has updated its SPAR operating procedures and there is now a concern form that can be completed to document concerns about prisoners. In this instance, a concern form might have been completed by the officer who took the call from Mrs Cassidy in the emergency control room or the Senior Officer it was passed to. This record could have been copied to House Senior Officers so they were made aware of what the concern was and what was being done to address it;
- Maghaberry Prison PSST now receives copies of the emergency control room Safer Custody Log and calls made to the prison switchboard during normal office hours. The details are entered onto a spreadsheet and PSST staff review the action taken and decide if they need to do any follow up work. Those who are asked to take forward any action in response to a call are expected to record what they did in their journal or preferably under inmate notes on Prisoner Record and Inmate System Management (PRISM). This process now enhances the information available to senior officers and PSST in Maghaberry Prison.

I acknowledge the introduction of the updated SPAR operating procedures which the Prison Service advised has provided a clear route and enhanced communication through multidisciplinary input to the new operating procedures and a new IT solution.

It is important that the work done by Maghaberry Prison PSST to ensure there is a mechanism for information provided by prisoner's families to be collated and follow up actions recorded is replicated across the Prison Service.

4.5 Was the response to the incident on 07 December 2018 effective and specifically was the initial response from Trust staff timely?

Staff reported no issues with the resuscitation response. The incident response was reviewed at the hot and cold debrief meetings. A number of points were raised and discussed – access through grilles and timeliness of response from healthcare, but none had an impact on the situation. Additional prison staff responded within minutes of Mr Cassidy being found, the first nurse was on the landing within six minutes and a paramedic arrived on the landing within 30 minutes. CPR was maintained throughout.

Standard 25 of the Prison Service Suicide and Self Harm Prevention Policy 2011 (updated 2013) states that hot and cold debriefs must take place following a serious incident of self-harm or death in custody.

The hot debrief should take place as soon after the incident as possible and involve all the staff, where possible, who were closely involved with the incident. The purpose is to provide staff with an opportunity to express their views in relation to how the situation was discovered and managed, and any additional support or learning that could have assisted.

The cold debrief is expected to take place within 14 days of the incident and aims to provide further opportunity for staff to reflect on events and identify any additional learning. This also provides a further opportunity to check in with staff involved in an incident.

In comparison to some other cases, there was better representation at both meetings by Prison Service staff and Trust nurses who were directly involved in this incident. Prison staff raised no concerns about staff support. A point was discussed at the cold debrief meeting about individuals not feeling comfortable contacting Human Resources to arrange interviews/meetings and this was addressed by the Governor who chaired the meeting.

Professor Shaw had no concerns about the response to the incident and no concerns about the debrief procedures.

Were there opportunities to predict or prevent Mr Cassidy's death?

This was addressed by Professor Shaw. It was her view that Mr Cassidy's death could not have been predicted with any certainty and although there were missed opportunities in his care, these would not have prevented his death.

Mr Cassidy, she said, was always potentially at risk of self-harm and eventual suicide. It was therefore important to try and predict when someone may be at increased risk and then to provide them with ongoing and regular support/treatment. In her view the ongoing treatment should have included a review of his symptoms with appropriate treatment put in place and importantly good two-way communication between Prison Service and Trust staff.

Even with this type of approach she said it can still be difficult to predict an episode of self-harm and although this was recognised in Mr Cassidy's case with the opening of a SPAR, there was not a detailed exploration of what the current distress was about and how this related to the underlying information.

Section 5: Conclusions

With regard to my responsibilities to investigate Mr Cassidy's death and specifically considering the objectives of my investigation, I draw the following conclusions:

i) My investigation established the circumstances and events leading up to Mr Cassidy being found in his cell on 07 December 2018. These are set out in Section 3

ii) Mr Cassidy appears to have died as a result of the injuries he sustained after he was found hanging in his cell in Maghaberry Prison. An inquest to establish the cause of death is pending.

iii) I accept the view of Professor Shaw that Mr Cassidy's death could not have been predicted with any certainty and although there were missed opportunities in his care, these would not have prevented his death.

iv) I noted the opinion of Professor Shaw that prisons do not 'get to grips' with people like Mr Cassidy who have '*complex, sub-diagnostic*' needs and who do not meet the criteria for secondary mental health care.

v) Mr Cassidy's case presents a challenge for prisons to work out how best to manage people with multiple, complex issues and vulnerabilities coming into prison and who are a risk of self-harm. Prisons and their partner agencies are in a position of having to respond to this when community services have been unable to engage the individual or have not been aware of their needs. Mr Cassidy's case is 1 out of 5 deaths in custody in 2018, where a proposal has been made for the Prison Service and the Trust to adopt a new approach of case formulation and management to support the needs of this group. This must include proportionate information sharing with Prison Service staff. Notwithstanding the challenges around this, it is important that a conversation around this proposal begins to see if a workable approach can be found.

vi) I wrote to the Director, Reducing Reoffending, Department of Justice in August 2020 setting out the wider issues of concern which cases similar to that of Mr Cassidy's raise and asked that they are considered by the Departmental Health and Justice Improving Health within Criminal Justice Implementation Group. I would like to see some innovative thinking and proposals developed and tested on how we might engage with people such as Mr Cassidy differently to improve their lives, keep them safe and reduce the risk of them reoffending.

vii) My investigation report again raises questions for the Prison Service about its SPAR procedures and how it responds to information it receives from relatives who are concerned about someone in prison. I know that the Prison Service has changed its procedures for supporting people at risk. I seek an assurance from the Prison Service that their new arrangements address the weaknesses identified in the process in place at the time of Mr Cassidy's death.

viii) A number of healthcare issues were identified in relation to medication, when community mental health records were requested and that Mr Cassidy was discharged from the mental health team caseload before these notes were reviewed.

ix) Although Professor Shaw said that on balance it was unlikely that Mr Cassidy would have fulfilled the criteria for ongoing management on the secondary care caseload, she commented that he should not have been discharged from mental health team care before the community records, had been reviewed. I reiterate previous recommendations that community records should be requested at an earlier stage and make a recommendation to the Trust that a person is not discharged from the mental health team caseload until community records are reviewed.

x) I have addressed, as far as possible, the questions raised by Mr Cassidy's family and provided an explanation of the circumstances leading to his death. I sincerely regret the time taken to provide Mr Cassidy's family with the report of my investigation.

xi) In order to assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights, I will provide the Coroner with the materials underlying my investigation.

Section 6: Recommendations

The recommendation made in this report and the response from the Trust follows:

Recommendation 1

Community records: I recommend to the Head of Healthcare that community records should be reviewed before a patient is discharged from the mental health caseload.

This recommendation was not accepted by the Trust. The Trust said that while it was documented that Mr Cassidy had been discharged from the mental health team caseload this referred to him being discharged from his key worker rather than the mental health team and pointed to a referral to a steps to handling stress group. In the Professor Shaw's opinion the patient should continue to be assigned to a key worker until the community records are reviewed.