INVESTIGATION REPORT
INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

MR JAMES FLECK
AGED 24
WHILE IN THE CARE OF MAGHABERRY PRISON
ON 08 MARCH 2019

Date finalised: **22 February 2023**

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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 individuals in custody.

Investigation objectives 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 individuals in custody'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

CCTV	Close Circuit Television
CIWA	Clinical Institute Withdrawal Scale
CJINI	Criminal Justice Inspection Northern Ireland
COWS	Clinical Outcome Withdrawal Scale
CPR	Cardiopulmonary Resuscitation
DST	Dedicated Search Team
ECR	Emergency Control Room
EMIS	Egton Medical Information System
HSCB	Health and Social Care Board
IMB	Independent Monitoring Board
NICE	National Institute for Health and Care Excellence
NIPS	Northern Ireland Prison Service
PACE	Police and Criminal Evidence (Order) NI
PECCS	Prisoner Escorting and Court Custody Service
PIPE	Psychologically Informed Planned Environments
PSNI	Police Service of Northern Ireland
PRISM	Prisoner Record and Inmate System Management
SEHSCT	South Eastern Health and Social Care Trust
RQIA	Regulation and Quality Improvement Authority
SPAR	Supporting Prisoners at Risk (procedure)
SPAR EVO	Supporting People at Risk Evolution (procedure)
The Prison Service	Northern Ireland Prison Service
The Trust	South Eastern Health and Social Care Trust

Foreword from the Ombudsman

The death of a loved one is always difficult. The fact that a death occurs while someone is in prison custody has particular difficulties. Families have already experienced a loss when a loved one is taken into custody and they must place trust 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 will address and inform several interested parties, all of whom will learn from the findings.

It is critical that, as far as we can, we provide explanations and insight to bereaved relatives. I am grateful to Mr Fleck's family 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 Fleck's death.

Mr Fleck died in hospital on 08 March 2019, after being found unresponsive in his cell in Maghaberry Prison on Sunday 03 March 2019. He was 24 years old.

Mr Fleck's records show a young man who was faced with many complex issues and challenges. He had experienced significant traumatic events in his short life such as the death of his best friend in a road traffic accident, the death of his girlfriend and grandfather as well as social stressors such as living under paramilitary threat and experiencing drug misuse and addiction. He had a history of anxiety, depression and self-harm and a longstanding opiate and benzodiazepine dependency. He was not engaged in support for his mental health or addictions.

Mr Fleck was remanded to Maghaberry Prison on Saturday 02 March 2019. A risk assessment was completed on his committal and he was found to be at risk of self-harm or suicide. The prison's Supporting People at Risk Evolution (SPAR Evo) operating procedures were initiated and he spent his first night of custody in Special Accommodation[1] in Quoile House. Prison Officers monitored him every 15 minutes.

On the morning of Sunday 03 March 2019 the Senior Officer chaired a care plan review in the cell with Mr Fleck. All parties present agreed to move Mr Fleck from Special Accommodation to a regular cell in the committal house known as Bann

[1] Special Accommodation or Observation Cells are cells designed for individuals in custody deemed to be at risk of serious self-harm. They are designed without ligature points and have CCTV to allow the individual to be observed as often as necessary.

House and that the frequency of Mr Fleck's observations should be reduced from every 15 minutes to every 60 minutes. He remained on a SPAR Evo care plan.

Mr Fleck attended the yard in Bann House on the afternoon of Sunday 03 March 2019 and made a telephone call to his partner. He was locked in his cell at approximately 16:30, which is the regime at the weekend. Mr Fleck was observed approximately every 30 minutes throughout the evening of Sunday 03 March 2019. When he was checked on by a Prison Officer at 20:40 he was observed, "sitting up in bed."

When a Prison Officer lifted the flap on the cell door at approximately 21:05 Mr Fleck seen to be unresponsive. Prison Officers raised the alarm, entered the cell and attempted to resuscitate him with the help of Trust staff who arrived shortly after the alarm was raised. An ambulance and paramedics arrived at approximately 21:40 and secured a pulse. Mr Fleck was carried out of his cell on a stretcher at approximately 22:00 and was transferred to Craigavon Area Hospital where he remained in the Intensive Care Unit until his death on Friday 08 March 2019.

The Clinical Reviewer concluded that overall the care provided to Mr Fleck by Trust staff was of a reasonable standard and equivalent to the care he would have received in the community. There was no indication that Mr Fleck was at imminent risk of suicide or self-harm and the emergency response was well delivered and in line with resuscitation guidelines.

My report contains 4 recommendations aimed at improving the care of those in custody.

I am particularly conscious that Mr Fleck was 24 years old at the time of his death and that he had been in custody eight times in the last five years of his life. He was open about his addictions and mental health challenges and reported them to Healthcare in Prisons and prison staff at committal. In this, as in so many other situations, I am concerned that individuals with significant addictions, anxiety and depression find themselves in custody. The fact that Mr Fleck was in prison is a matter for the courts. And yet, he is not alone in returning to prison on a number of occasions while continuing to be medicated for anxiety and depression and in need of addiction services.

In a request to the Director, Reducing Offending and representatives of the South Eastern Health and Social Care Trust (the Trust) on 19 August 2020, I raised concerns about adequate information being shared between community and prison care and between services working within prisons to ensure that individuals in custody received the best possible healthcare. My request was specifically that alternative models of care arising from current death in custody investigations be examined. The Regulation and Quality Improvement Authority (RQIA) report published in October

2021, *Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons*, goes some way to addressing my request and I discuss this in further detail throughout this report.

Mr Fleck was open about not wanting to address his addictions and about not being in need of support. Inevitably, both Healthcare in Prisons and the Prison Service are in the unenviable position of supporting a young man in such a situation but with limited resources to do so.

I am encouraged that despite Mr Fleck feeling he did not require support at the time of his committal he was assessed as being at risk. My investigation examines this issue closely and I am glad to confirm that Mr Fleck received the necessary healthcare supports and management by the Prison Service to keep him as safe as was possible. This is a challenging situation for Prison Officers who are dealing with someone convinced they are not in need of help when they have been assessed as being at risk.

Sadly, despite the standard of care and attention Mr Fleck received he lost his life. The post mortem report examination found that the cause of death was pneumonia due to cerebral hypoxia, due to hanging. An inquest is pending and at that inquest, the Coroner will decide the cause of death. I reiterate my condolences to Mr Fleck's family and friends.

I am grateful to the Prison Service, the Trust and the clinical reviewer 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
22 February 2023

Section 1: Recommendations

1.1 Recommendations List and Factual Accuracy Responses

Recommendation 1: SPAR Evolution Review The Prisoner Ombudsman welcomes the commissioning of an external review of SPAR Evo as recommended in the Regulation and Quality Improvement Agency (RQIA) review of the Care of Vulnerable Persons Detained in NI Prisons (2021) and recommends that a copy be sent to the Prisoner Ombudsman on completion.
The Prison Service accept this recommendation.
Recommendation 2: Improving recording of personal triggers to self-harm That the Prison Service and South Eastern Health and Social Care Trust monitor both SPAR Evo and risk sharing information to establish whether personal triggers leading to self-harm are recorded and if improvements could be made.
The Prison Service and the Trust do not accept this recommendation.
Recommendation 3: SPAR Evolution training That the Prison Service ensure a programme of regular refresher training is provided to all relevant staff as and when required to ensure the integrity of the SPAR Evo approach.
The Prison Service accept this recommendation.
Recommendation 4: Recording and responding to family concerns That the Prison Service reinforce the importance of family concerns to all staff to ensure that family concerns are appropriately recorded and appropriate follow up action is taken, including notifying Trust staff if a concern about mental health is raised.
The Prison Service accept this recommendation.

Section 2: Background information

2.1 Maghaberry Prison

Maghaberry Prison is a high security prison, where male adults who are sentenced and on remand are held in custody. The population in the prison at the time of the incident involving Mr Fleck was 807 which is within normal operational levels. It has a Prisoner Safety and Support Team (PSST) whose responsibilities include supporting vulnerable individuals in custody who are at risk of suicide or self-harm.

Since 2008, the Trust has provided Healthcare in Prisons. There is a 24 hour primary care service. The primary care staff all have some Mental Health training in addition to their core training. The Mental Health Team was on site Monday to Friday between 08:00 and 17:00 at the time of Mr Fleck's death. Since 30 October 2020 the Mental Health Team commenced a pilot to provide a service seven days a week in Maghaberry Prison. Staffing this can be challenging as it requires stretching the original five day staffing resource over seven days. The Commissioners of Healthcare in Prisons are aware of the need for more funding to guarantee a seven day service across all sites. Also from October 2020 all Mental Health Committal Screens Triage take place face-to-face.

2.2 Criminal Justice Inspection (CJINI)

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

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

In November 2019 CJINI published the *Safety of Prisoners Report*, which highlighted identifying really vulnerable individuals within the prison population as one of the most difficult issues facing the Prison Service. To respond to this challenge the Prison Service would have to work to create a therapeutic environment to help stabilise individuals at risk and manage their imprisonment more safely.

An Inspection Report is anticipated in early 2023.

2.3 Regulation and Quality Improvement Authority (RQIA)

The RQIA is the independent body responsible for regulating, inspecting and reviewing the quality and availability of health and social care service. In the course of their reviews RQIA identify best practice and highlight gaps or shortfalls in services requiring improvement. All their reviews aim at protecting the public interest.

Following a report from my Office of an incident of serious self-harm in 2016, and the number of suicides in prisons a review was commissioned jointly by the Departments of Health and Justice.

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 individuals in custody received the best possible healthcare. My request was specifically that alternative models of care arising from current death in custody investigations be examined. The RQIA review, completed and a report published in October 2021 (*Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons*), goes some way to addressing my request.

2.4 Independent Monitoring Board (IMB)

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

The 2018-19 IMB annual report for Maghaberry Prison reiterated the 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 Board reported that Maghaberry Prison was now a safer and more stable environment than previously and recognised developments in safer custody.

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

2.5 Prisoner Escorting and Court Custody Service (PECCS)

PECCS is the prisoner transport and escorting service. PECCS is responsible for the safe operation of the cell holding areas in each courthouse in Northern Ireland. PECCS staff were responsible for Mr Fleck's care at court and for transferring him safely to Maghaberry Prison.

2.6 Previous incidents at Maghaberry Prison

Mr Fleck's death was the only serious adverse incident that resulted in death whilst in the custody of Maghaberry Prison during 2019. One other serious adverse incident resulting in death also occurred in 2019 when another individual in custody was on compassionate bail. The incidents were not related.

PART A: INVESTIGATION AND FINDINGS

Section 3: Framework and scope for this investigation

Mr Fleck died at hospital on 08 March 2019. He died as a consequence of injuries he sustained while in the care of the Prison Service, 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 Fleck's family.

3.1 Questions raised by Mr Fleck's family

Mr Fleck's family raised a number of questions relevant to my investigation when they met with me after his death. These are summarised below:

- What was the exact timeline of events from Mr Fleck's committal to his arrival at hospital?
- Were the Prison Service aware of Mr Fleck's volatile behaviour while in police custody, was he was believed to be under the influence of drugs or alcohol and what treatment did he receive for this and what assessment was made of his risk of self-harm/suicide when he arrived in Maghaberry Prison?
- What was the nature of the assessment of Mr Fleck's risk of self-harm and suicide? Was he on 'suicide watch' at the time of his death? How frequently he was monitored? Was this appropriate?
- Had Mr Fleck received any medication?
- How was Mr Fleck able to hang himself with a sock? Why was the light fitting that was in the cell able to hold the weight of Mr Fleck's body?

- When was Mr Fleck last seen alive? How long it was before he was cut down and before CPR was administered? Was a defibrillator used while Mr Fleck was still in the prison?
- Why were Mr Fleck's family not notified of the incident until 23:00 when he was first found shortly after 21:00?

3.2 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 the Investigating Officer:

- Prison Service records including Close Circuit Television (CCTV) footage, radio transmission recordings and telephone calls made by Mr Fleck prior to his death;
- Interviews with prison staff;
- Interviews with individuals in custody; and
- Healthcare records.

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

3.3 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 peer review of healthcare provision, and they provide a report with recommendations. My office provide relevant documentation and reviewers receive a terms of reference specific to each case. They provide an independent, expert opinion about care provided by:

- assessing the appropriateness of care provided and whether or not provision has been in line with current clinically approved guidelines, local and national
- providing an opinion about whether or not the healthcare received in prison was equivalent to what would be provided in the community
- identifying any learning which would assist either the Prison Service or Healthcare providers in future
- identifying any examples of good practice.

The clinical reviewer will take all matters into consideration to provide a view on whether or not a death could have been predicted or prevented. In Mr Fleck's case I

also invited the clinical reviewer to examine how and when Mr Fleck died and any potential root causes for his death which could have been identified during his time in custody.

The clinical review of the healthcare provided to Mr Fleck was conducted by Mr Terry Dutchburn MSc, BA (Hons), RMN. Mr Dutchburn has previous experience in both the commissioning and provision of healthcare within HMP New Hall and HMP Wakefield, and commissioning Death in Custody reviews at both these establishments while he was Director of Commissioning at Wakefield West Primary Care Trust. He has over 40 years' experience in healthcare, working as a Senior Nurse, Senior Manager and Director within the NHS. He has completed more than 100 death in custody clinical reviews for NHS England and the Prison and Probation Ombudsman for England and Wales.

Mr Dutchburn was also invited to highlight any other issues he thought could be important. He provided me with a report setting out his opinion on the matters he was asked to consider. I have included his opinion on relevant matters in this report.

3.4 Scope and remit of the investigation

The scope and remit of my investigation must meet the standards set out in Terms of Reference for Prisoner Ombudsman NI investigations of deaths in custody. These apply to every investigation and are found on Page 2 of this report and more fully at Appendix 1. These overarching Terms of Reference, together with questions from the family and Terms of Reference for the clinical review, inform the scope and objectives of this investigation which are:

1	Examine if Mr Fleck's primary and mental health needs were appropriately managed from his committal until his transfer to hospital, including his medication management;
2	Examine if Mr Fleck was managed effectively, in accordance with the Suicide and Self Harm Prevention Policy (2011) (Updated 2013) and if the decision to remove Mr Fleck from Special Accommodation on 02 March 2019 and reduce his observations to 60 minutes was satisfactory and commensurate with the assessed risk; Identify any learnings which might contribute to the development of SPAR Evo.
3	Consider if the response to Mrs Fleck's telephone call to the prison on 03 March 2019 was appropriate;

4	Determine if the response by the Prison Service and the Trust when Mr Fleck was found hanging was conducted in line with the relevant guidance; and
5	Assess if the Prison Service liaison with Mr Fleck's family immediately following the incident was adequate.

The investigation will also highlight any areas of good practice.

A description of the key events leading up to Mr Fleck's death is set out in Section 4.

Section 4: Description of key events

Mr Fleck had been in custody on eight previous occasions – once at Hydebank Wood College and seven periods at Maghaberry Prison. He had spent three years and three months of the previous five years in custody. His last period of custody was for one day on 27 September 2018. Prior to this he had been living in the community for over five months.

Mr Fleck had a history of anxiety and depression and had a longstanding opiate and benzodiazepine dependency. He did not engage in any sustained support for his mental health or addictions.

4.1 Saturday 02 March 2019: Committal to Maghaberry Prison

Mr Fleck was transferred from Police Service of Northern Ireland's (PSNI) custody into the care of the Prisoner Escort and Court Custody Service (PECCS) at Laganside Courts on Saturday 02 March 2019. PSNI Prisoner Escort Records stated that Mr Fleck was observed to be highly agitated and volatile during his stay in police custody. He attempted to self-harm while in custody, at one point attempting to use clothing as a ligature and another by banging his head against a wall, for which he had to be restrained. A hand written note on the front of the report stated Mr Fleck had 'non-current thoughts of self-harm.'

Mr Fleck's PECCS Prisoner Escort Records stated that he had a history of self-harm or suicide attempts and had used drugs or alcohol prior to coming into custody.

Mr Fleck arrived at Maghaberry Prison just before 14:00. He was one of seven new committals that day and was placed in a holding room in the reception area along with a number of other individuals in custody.

All individuals coming into prison go through a formal committal process which includes a search of their person, a property log and a warrant check. They have their personal details inputted to the prison's computer system and attend a committal interview with a member of reception staff and an initial healthcare assessment with a nurse.

At approximately 14:50 Mr Fleck was moved into a single holding room. This was because he began to remove his clothes and threatened to use them to make a ligature. In the single holding room Mr Fleck removed all of his clothes and attempted to tie a ligature around his neck. At this point Prison Officers removed Mr Fleck's clothing from the cell for his safety. When asked directly why he was removing his clothes, Mr Fleck stated repeatedly that he wanted to see the medic.

Senior Officer A arranged for him to see the nurse. Mr Fleck's clothing was returned to him and at 14:54 he left the holding room and was escorted to the healthcare room for a committal assessment[2] with Nurse A.

The assessment Nurse had access to Mr Fleck's Police and Criminal Evidence (Order) NI (PACE) notes from police custody as part of Mr Fleck's committal assessment, which recorded that he appeared to be intoxicated and his behaviour was volatile. The nurse checked the Electronic Care Record for details of current medications and appointments. During the course of the assessment Mr Fleck disclosed:

- An extensive history of self-harm most recently cutting his arm the previous night due to no Temazepam. Marks to his arms were noted.
- A dependency on Benzodiazepines. His current medications were Temazepam, Diazepam, Pregabalin, Seroquel, Propranolol and Mirtazapine.
- That he required Benzodiazepine medication. He inferred that if he did not have both Diazepam and Temazepam he would be at risk of seizures.
- A history of outpatient and inpatient mental health care for anxiety, borderline personality disorder and depression.

Egton Medical Information System (EMIS) notes completed at 14:57 record that Mr Fleck appeared under the influence of unknown substances and was pre-occupied with medications. Nurse A was unable to assess him for Benzodiazepine withdrawal due to his "aggressive and threatening" behaviour and withheld Mr Fleck's prescription medication because of concerns about what he may have already taken. When Nurse A informed Mr Fleck of this decision he threatened to "flip the table" onto her and was escorted from the room by a Prison Officer before the assessment could be completed. Nurse A recorded that they were unable to complete the assessment or ask Mr Fleck if he had any current thoughts of suicide or self-harm. Nurse A made arrangements for Mr Fleck's relevant prescriptions to be generated.

Mr Fleck was escorted to a single holding room where he again removed his clothes and attempted to tie a ligature around his neck. As had happened previously, Mr Fleck's clothing was removed from the cell by Prison Officers for his own safety. A privacy screen was placed in front of the holding room. At this point Mr Fleck's

[2] This assessment is conducted in line with NICE Guideline 57 Physical health of people in prison. The initial healthcare assessment is conducted in the prison reception within four hours of committal. The purpose of this screen is to gather information to keep an individual in custody safe during the early stages of their time in custody. The assessment focusses particularly on medication, alcohol and drugs misuse, immediate mental health issues (including risk of suicide and self-harm) and any conditions that fall under the critical medications list. This is followed by a comprehensive health screen within 72 hours of committal. This is usually conducted the day after committal.

behaviour was described as erratic and volatile and he shouted that he refused to comply with the committal process and he would go to “the block”.

At approximately 16:00 Senior Officer A entered the holding room and attempted to de-escalate the situation. Senior Officer A asked Mr Fleck what the problem was to which Mr Fleck replied that he needed his medication and a cigarette. Senior Officer A agreed to get Mr Fleck a cigarette on the understanding that he would then comply with the committal interview and full body search.

At 16:08 Mr Fleck’s clothes were returned to him and he was escorted outside for a cigarette. When he returned to reception at approximately 16:15 he apologised to Prison Officer A for his behaviour.

At 16:17 Mr Fleck participated in a committal interview with Prison Officer A. He told the Prison Officer the following:

- That he had a history of self-harm and last self-harmed two weeks previously by cutting;
- That he self-harmed when he did not get his medication;
- That he had a history of suicide attempts the most recent being two years previously;
- That nothing had happened in his life recently which might increase his thoughts of self-harm or suicide;
- That he had past involvement with mental health services but did not require any immediate support;
- That he was a regular drug user (heroin and ‘blues’), had no intention of changing and was suffering withdrawal symptoms.

Prison Service records show that Prison Officer A completed a risk assessment for Mr Fleck. It determined that Mr Fleck was at risk of self-harm or suicide and in response the SPAR Evo operating procedures were initiated section 4.2.

Mr Fleck made a committal telephone call at approximately 16:35 and spoke to his partner. They discussed his solicitor, his bail application and his possible sentence of 3 to 4 years. Mr Fleck appeared disappointed that his partner hadn’t yet booked a visit to see him and told her not to contact him. The call ended.

As is the process at committal, Mr Fleck participated in a full body search which was conducted by Prison Officer A and Prison Officer B at approximately 16:50. Nothing of note was found during the search.

4.2 Supporting People at Risk Evolution

At the time of Mr Fleck's committal to prison a new approach to supporting those at risk of suicide or serious self-harm had begun rollout at Maghaberry Prison in mid-February 2019. The new approach built on the existing SPAR, Supporting Prisoners At Risk, Process and is known as SPAR Evolution (SPAR Evo).

The aim of SPAR Evo is to ensure that individuals in custody who are at risk of self-harm or suicide receive multi-disciplinary care in an attempt to ensure their safety. SPAR Evo introduced a person-centred approach, giving staff more flexibility to create a bespoke care plan to address the individual needs of those in custody and take into consideration the individual's triggers, history and root causes.

At the time of Mr Fleck's death, SPAR Evo was in the early stages of its roll out across Maghaberry Prison and was not fully digitalised, as it is now. I will discuss this further in Section 6 of my report.

Part 1 of the SPAR Evo involves a risk assessment which is carried out when a Concern is formally raised. The Concern is documented and one of three possible outcomes to the risk assessment are reached:

1. No apparent risk
2. No apparent risk with referral
3. At risk

Mr Fleck was found to be **At Risk**. Prison Service records show that contributory risk factors for Mr Fleck were recorded as irrational behaviour, addiction to drugs and/or alcohol and a history of self-harm.

At 17:05 the Duty Governor, Governor A, authorised the use of Special Accommodation[3] and Protective Clothing[4], and recorded that Mr Fleck had, "poor eye contact, volatile. Used own clothing in holding cell as ligature. Threatened to kill himself when get chance. Very volatile, not happy he could not get medication he wanted." Governor A recorded that Nurse A verbally agreed to place Mr Fleck in Special Accommodation.

An immediate **Keep Safe** plan was put in place by staff who agreed that Mr Fleck would be observed every 15 minutes, both in person and by CCTV monitoring. Observations would be recorded in the SPAR Evo Log.

[3] Special Accommodation, also known as Safer or Observation Cells are special anti-ligature cells, which allow 24 hour telephone access to the Samaritans.
[4] Protective Clothing or Anti-Ligature Clothing is designed so that it cannot be used as a ligature.

4.3 Quoile House

Prison Officers B, C and D escorted Mr Fleck from reception to Quoile House at approximately 17:25. At interview the Prison Officer's reported that Mr Fleck appeared calm and he chatted to them about how he had ended up in Maghaberry Prison.

Shortly after arriving in Quoile House, at 17:32, a discipline alarm was raised and Mr Fleck was held under close escort and then under restraint using a procedure called Control and Restraint[5], close to the door of Cell 30 on Landing 4. This was because he became noncompliant and resisted being placed in Special Accommodation.

At 17:35 Prison Officer's E, F and G from the prison's Dedicated Search Team (DST) arrived in Quoile House. They relocated Mr Fleck from the landing into Special Accommodation and placed him in Protective clothing. DST staff left and Mr Fleck was locked in his cell (Landing 4, Cell 30) at 17:40. Senior Officer B recorded that Mr Fleck presented as very agitated and continued to issue verbal threats to staff.

When someone is held in Special Accommodation, they are monitored by CCTV. A Prison Officer keeps a real time record of the person in the cell, and any behaviour of concern is relayed to landing staff via radio. In Mr Fleck's case the CCTV footage from inside his Special Accommodation was unavailable for my investigator to view due to a fault in the recording system, however the real time records were available and have been viewed.

Mr Fleck activated his cell bell twelve times between 17:39 and 18:47 and made two calls to the Samaritans (17:40:17 12 seconds & 17:41:09 7 seconds). He blocked the in-cell camera and continued to be verbally abusive towards staff. The SPAR Evo Log records Mr Fleck as responding aggressively when asked to clear the CCTV camera, hitting the cell door and bouncing the toilet door off the wall while shouting obscenities to staff.

At 17:42 Nurse B attempted to talk to Mr Fleck at the cell door following the Control and Restraint incident. This was in order to complete an assessment, required when Control and Restraint is applied[6]. Nurse B recorded that Mr Fleck became, "violent

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[5] Control and Restraint is a term used when officers, only when absolutely necessary have no other option but to use reasonable and proportionate force to secure their own or any other person's safety. All discipline staff are taught Control and Restraint techniques and it is designed to be done as safely as possible for both staff and individuals in custody. It is not a comfortable experience for either officers or individuals and healthcare always attend an individual after an incident of Control and Restraint.

[6] An IMR12 assessment is carried out by a member of Trust staff after an incident of Control and Restraint. This is to record any injuries incurred as a result of the incident, so these can be monitored accordingly.

and aggressive in cell. Tried to talk to James through door window, continued to shout and bang in cell. At present I felt it was too dangerous to enter James' cell to complete assessment."

At 17:45 Mr Fleck's SPAR Evo log book records "given tea meal and cigarettes," by Prison Officer H.

4.4 First night in custody

Healthcare records show that Mr Fleck retired to bed at approximately 23:00 with no complaints reported to landing staff. Mr Fleck's medications were withheld as there was uncertainty regarding what substances he may have taken and the possibility of adverse reactions.

Records show regular 15 minute observations were conducted through the flap of the cell door for the remainder of that evening and throughout the night. CCTV confirms that Mr Fleck was checked 60 times between being locked in his cell on Saturday 02 March until the day staff arrived on Sunday 03 March at 07:30.

The SPAR Evo Log entry at 07:26 on Sunday 03 March records Night Custody Officer I, "Prisoner had a quiet night, no issues expressed."

4.5 Sunday 03 March 2019

CCTV records show that Prison Officer J talked to Mr Fleck at his cell door at 08:03 on Sunday 03 March 2019. The SPAR Evo log records that he refused to engage with the Prison Officer.

At 08:43 Prison Officers from the DST entered Mr Fleck's cell and spent approximately three minutes searching it. This was because there was suspicion that he was in possession of drugs. Nothing was found.

At 08:47 Senior Officer C talked with Mr Fleck for approximately five minutes through the flap in the cell door. During this conversation he is recorded as requesting medication, to which he was advised that he could speak with a nurse. Senior Officer C left the cell door at 08:52 and returned at 08:56, opened the cell door and gave Mr Fleck some cigarettes. Senior Officer C offered him a cup of tea but he declined and requested a drink of water. Senior Officer C remained talking to him for a further three minutes.

At 09:06 two officers entered Mr Fleck's cell to supervise him brushing his teeth, and give him a drink of water and toilet roll.

At 09:29 Senior Officer C and Prison Officer K opened the cell door and talked with Mr Fleck for approximately five minutes. The SPAR Evo Log records that he was offered some breakfast and told that the nurse would be around shortly to see him.

Mr Fleck was given some breakfast in his cell at 09:38 but is recorded as having thrown it around his cell at 09:48.

At 10:11 Senior Officer C and two other staff spoke to Mr Fleck at the door of his cell. The Senior Officer advised Mr Fleck that if he had an issue then he should talk to the staff who would attempt to get the issue resolved. Mr Fleck agreed and apologised for his actions. The conversation ended at approximately 10:20.

4.6 Supporting People at Risk Evolution - Review

Senior Officer C chaired a SPAR Evo review with Mr Fleck at approximately 10:35 in Mr Fleck's cell. Prison Officer K and Nurse D also attended. Senior Officer C noted that Mr Fleck engaged well throughout the review and that Mr Fleck was frustrated about being in Special Accommodation. He denied being under the influence on committal but confirmed that he was a regular drug user in the community and did not want help with his addictions. The records shows that Mr Fleck said he had no thoughts of self-harm or suicide and his only issue was not receiving his medication.

All those present agreed that Mr Fleck would remain on SPAR Evo but would move to a regular cell in Bann House, the prison's committal unit, and his observation intervals would be reduced from 15 minute intervals to 60 minute intervals. The review concluded at approximately 10:51.

At 10:54 Nurse D administered 7mg of diazepam to Mr Fleck in his cell. Nurse D conducted observations of Mr Fleck and recorded in EMIS that he "expressed annoyance in relation to Temazepam. Stated that he needed an alternative. James was advised that the out of hours may not prescribe anything, annoyed by same. Advised I will contact Lagandoc to discuss with them."

4.7 Bann House

Mr Fleck left Quoile House at approximately 11:30 and was escorted to Bann House by Senior Officer C and Prison Officer K, where he arrived at approximately 11:42. Mr Fleck appeared calm except for one further issue as he was leaving Quoile House when he verbally abused a prison officer. Prison Officer K recalled at interview that Mr Fleck apologised to him and Senior Officer C for having to escort him to Bann House.

Upon arrival at Bann House, Senior Officer C gave a verbal handover to Bann House, Senior Officer D, describing that morning's events and interactions with Mr Fleck and checking that the SPAR Evo booklet had been completed correctly.

Prison Officer K walked Mr Fleck through Bann House and presented him to Prison Officer L. At interview Prison Officer K recalled Mr Fleck talking and shaking hands with people he knew as he walked through Bann House. Mr Fleck told Prison Officer K and Prison Officer L that he wanted a single cell. Prison Officer K gave a detailed verbal handover to Prison Officer L, including an overview of Mr Fleck's period in Quoile House and his recent SPAR Evo Case Review.

At 11:56 Mr Fleck attended a Comprehensive Committal Assessment[7] with Nurse A in the healthcare room of Bann House. EMIS notes record Mr Fleck's history of self-harm and substance misuse. Nurse A explored Mr Fleck's substance misuse history, documenting that Mr Fleck was adamant that he was not under the influence at committal and denied any recent drug use. Nurse A documented that there was no evidence of any drug withdrawal symptoms and Mr Fleck's physical observations were all within normal limits. Nurse A also noted that Mr Fleck was pre-occupied with his medications and was advised that medications are administered "when it is safe to do so." Mr Fleck denied any thoughts of suicide or self-harm. The assessment ended at 12:04 and Mr Fleck was locked in his cell (Cell 13, Landing 2) in Bann House. He had been allocated a single cell.

Prison Officer M was asked to attend the assessment as a precaution, given Mr Fleck's volatile behaviour at the Initial Committal Assessment. At interview Prison Officer M noted that Mr Fleck became agitated when discussing medication, raised his voice and was verbally aggressive to Nurse A. He did not require restraining by prison staff.

Sometime between 11:42, when Mr Fleck arrived in Bann House and 14:10, when Mr Fleck went out to the yards, Prison Officer M, who was stationed in Bann House Class Office, received a telephone call from the Emergency Control Room (ECR) to say that Mr Fleck's mother had contacted the prison. At interview Prison Officer M could not recall the exact time of the call or the exact message but stated that Mr Fleck's mother had asked for him to contact her. My investigation could find no written record of the call being received in the ECR or Bann House.

Prison Officer M recalled verbally passing the telephone message on to a colleague, Prison Officer N who was working on the Bann 2 landing and carrying out Mr Fleck's

[7] A Comprehensive Committal Assessment (CCA) is part of the committal process and follows the Initial Assessment conducted in reception. Its aim is to gather more information about the patient.

SPAR Evo observations. Prison Officer N recollected writing the message down on a post-it note, and possibly a telephone log, although this was unable to be verified.

Mr Fleck was offered a committal telephone call to contact his mother before the afternoon yards at 14:10. He declined the offer. Mr Fleck was offered the use of the Bann House exercise yard in the afternoon which he accepted and used from 14:10 until 15:40. He remained under observation via CCTV during this time.

During yard association between 14:10 until 15:40, Individual A alleged that he spoke to Mr Fleck, who appeared concerned that he did not have any tobacco because the Prison Officers would not pass him any. Individual A alleged that he told Mr Fleck not to worry and that he would pass him some tobacco. At interview he recalled that Mr Fleck's mood was not concerning to him but he was aware that he was on regular observations for his SPAR Evo.

Prison Officer N stated at interview that he recalled Mr Fleck did have tobacco, and some cigarettes. PSNI photographs show a pouch of tobacco in Mr Fleck's cell.

Mr Fleck was offered an additional committal telephone call to contact his mother when he returned from the yard at 15:40. Mr Fleck chose to call his partner and this call was facilitated at 16:26.

During the call Mr Fleck's partner told him that his mother wanted him to call her. He asked why and his partner said it was because she was upset. Mr Fleck explained that he only gets one call and was using it to phone her. He reported to his partner that he had tried to strangle himself yesterday and was in Special Accommodation the previous night. He expressed concern that his partner wouldn't be able to visit him because of her own bail conditions and she replied that she was trying to appeal those so she could visit. They discussed the people they had approached unsuccessfully for a bail address and his partner reassured him that she would keep trying. They also discussed Mr Fleck's solicitor and current situation. Mr Fleck told her he had, "no clothes, no tobacco" and asked her for money. She told him that she had £25 for him and would get his clothes. The call ended at 16:31 with them saying "I love you".

Mr Fleck was locked in his cell at approximately 16:30, which is the normal regime at weekends.

4.8 Events of the evening of Sunday 03 March 2019

Despite the decision to reduce Mr Fleck's observation intervals from every 15 minutes to every 60 minutes, Mr Fleck was monitored by staff in Bann House approximately every 30 minutes. Between 16:30 and 19:20 CCTV confirms that Mr Fleck was checked by staff 10 times.

The last conversation check with Mr Fleck was recorded at 19:20 when Prison Officer O asked him if he was okay and Mr Fleck replied, "yeah." Prison Officer O recorded in the SPAR Evo log that Mr Fleck appeared calm and relaxed.

At 19:46 a Prison Officer O observed Mr Fleck lying awake on the top bunk. At 20:12 records show he was observed in bed with the TV on and 20:40 he was sitting up in bed.

At 21:05 Prison Officer O checked Mr Fleck again. When Prison Officer O lifted the flap he saw Mr Fleck unresponsive. He immediately sent an urgent Code Blue message, the emergency radio code for an unconscious individual in custody, over the radio. A colleague from Bann landings 3 and 4, Prison Officer P, responded immediately.

At 21:07 Prison Officer O broke open his emergency key pouch and unlocked the cell door. The two Prison Officers entered the cell, Prison Officer O supported Mr Fleck's weight and with Prison Officer P lowered Mr Fleck onto the cell floor, checked for a pulse, none was found and Cardio Pulmonary Resuscitation (CPR) commenced immediately.

CCTV and Body Worn Camera Footage confirm the following series of events:

- At 21:08 Senior Officer E arrived on the landing, requested an emergency ambulance and entered the cell.
- At 21:09 Senior Officer E left the cell.
- At 21:10 Nurse C arrived at the cell door followed by Nurse E. Senior Officer E returned to the cell.
- At 21:11 Senior Officer E left the cell and returned at 21:12 with a small red bag containing the defibrillator.

The three Prison Officers and two nurses continued to try to resuscitate Mr Fleck. He was unresponsive and no pulse was detected. The defibrillator did not advise a shock. Healthcare in Prisons staff administered Naloxone, an opioid blocker. While efforts were being made to resuscitate Mr Fleck, two Prison Officers from other locations in the prison were redeployed to escort him to hospital.

- At 21:28 Prison Officer Q and Prison Officer R arrived on the landing. Prison Officer Q kept a log of events from the cell door.
- At 21:38 two paramedics arrived in the cell. They took the lead in the resuscitation effort and were assisted by the Prison Officers and Nurses who were present. The paramedics administered a cardio shock and shortly afterwards a pulse was detected.

- At 21:58 Mr Fleck was carried out of his cell on a stretcher by two paramedics.

Mr Fleck left the prison estate at 22:10 and was taken by ambulance to Craigavon Area Hospital. He arrived at the hospital at 22:38.

At 22:10 the Duty Governor, Governor A, held a Hot Debrief for the staff involved in the incident in the Class Office of Bann House. Senior Officer E, Prison Officer O, Prison Officer P, Nurse C and Nurse E also attended.

The sequence of events were discussed and Governor A advised staff of support services that were available to them. Healthcare in Prisons staff in attendance were unable to tidy up their equipment in the cell because the latter had been sealed as a potential crime scene, as is procedure. CCTV confirmed that Mr Fleck's cell was sealed with an isolation bar at 22:21.

The meeting terminated at 22:23 with Prison Officer O and Prison Officer P going off duty shortly thereafter. Governor A contacted Senior Governor B following the Hot Debrief. The exact time of this contact is unknown. Governor A requested approval to notify Mr Fleck's next of kin that he had been taken to hospital. This was granted by Governor B. Governor A attempted unsuccessfully to contact Mr Fleck's next of kin by landline at 22:31 and 22:41 and mobile at 22:32 and 22:42.

At 22:45 prison staff who had escorted Mr Fleck to hospital advised the prison's ECR that doctors had asked for his family to be contacted. As Governor A had not been able to contact the next of kin directly they asked the police to attempt to make contact in order to avoid any further delay. At 23:16 the police contacted Maghaberry Prison to confirm that they had made contact.

A Cold Debrief was held on 04 April 2019 and attended by Governor A, Governor B, Prisoner Safety and Support Governor, Governor C, Senior Officer E, Prison Officer O and Prison Officer P. Minutes of the meeting record that Governor A and Governor B praised staff for their quick response to the incident. Available aftercare for staff and individuals in custody was advised.

4.9 Events until Friday 08 March 2019

Mr Fleck was taken to the Intensive Care Unit at Craigavon Area Hospital where Prison Officers kept a bed watch log of events.

On 05 March 2019 Governor D attended the hospital and released Mr Fleck under Prison Rule 27.[8]

Mr Fleck was declared deceased at 21:40 on 08 March 2019.

A Post Mortem was completed on 09 March 2019 and recorded Mr Fleck's cause of death as pneumonia due to cerebral hypoxia due to hanging.

Section 5: Family Questions

5.1 Family Questions

I have set out the events and circumstances leading up to Mr Fleck's death in Section 4. This should provide some insight for Mr Fleck's family about his journey from the day he was committed to Maghaberry Prison until he was taken to hospital.

In Section 3.1 I listed the questions the family asked me to address during the course of my investigation. I have answered these below:

1. What was the exact timeline of events from Mr Fleck's committal to his arrival at hospital?
This is detailed throughout Section 4.
2. Were the Prison Service aware of Mr Fleck's volatile behaviour while in police custody, was he was believed to be under the influence of drugs or alcohol and what treatment did he receive for this and what assessment was made of his risk of self-harm/suicide when he arrived in Maghaberry Prison?
The PACE notes from Mr Fleck's period in police custody indicated his volatile behaviour and described 2 attempts to self-harm – once by banging his head against a wall and another by using his clothing to tie a ligature around his neck. Prison Service records indicate that Mr Fleck's PACE notes were received by prison reception staff and Healthcare in Prisons staff. Mr Fleck disclosed to Nurse A that he most recently self-harmed the previous evening whilst in police custody. At interview, reception Prison Officers were confident that they reviewed the PACE notes for Mr Fleck and were aware of his recent history in police custody.

[8] Rule 27 (2) prisoner may be temporarily released under this rule for any special purpose or to enable him to have health care , to engage in employment, to receive instruction or training or to assist him in his transition from prison to outside life.

Mr Fleck was suspected of being under the influence of illicit drugs by the committal nurse, Nurse A, who withheld medication on Saturday 02 March 2019 because of safety fears. Mr Fleck was assessed by prison and Healthcare in Prisons staff as being at risk and was placed on a SPAR Evo care plan on Saturday 02 March 2019. He was moved to Special Accommodation in Quoile House and issued with Protective Clothing. Prison staff monitored Mr Fleck at 15 minute intervals until he was moved to Bann House on Sunday 03 March 2019, where he was monitored by staff at 30 minute intervals.

3. What was the nature of the assessment of Mr Fleck's risk of self-harm and suicide? Was he on 'suicide watch' at the time of his death? How frequently was he monitored? Was this appropriate?

Mr Fleck was assessed as being at risk of self-harm or suicide by prison and Healthcare in Prisons staff on Saturday 02 March 2019. He was accommodated in Special Accommodation in Quoile House and issued with Protective Clothing. Mr Fleck was observed at 15 minute intervals and was under CCTV observation.

Mr Fleck covered the CCTV camera for most of the time that he was accommodated in Special Accommodation and, due to technical difficulties, the CCTV did not record. I have therefore been unable to review it as part of this investigation.

Following a SPAR Evo review meeting on the morning of Sunday 03 March 2019 Mr Fleck was moved to a standard cell on the committal landing of Bann House (Landing 2, Cell 13). He remained on a SPAR Evo care plan and was monitored at 30 minute intervals. I discuss the appropriateness of this decision making in Sections 6.1 and 6.2 of my report.

4. Had Mr Fleck received any medication?

Mr Fleck's medication was withheld due to concerns for his safety in relation to intoxication on Saturday 02 March 2019.

Mr Fleck had received the following medications on Sunday 03 March 2019:

- Diazepam 7mg in the morning and evening
- Pregabalin 300mg in the morning and afternoon
- Quetiapine 25mg x2 in the morning
- Mr Fleck refused Propranolol 40 mg in the morning and evening

- Mr Fleck was written up for Mirtazapine 45 mg but records state patient unavailable

5. How was Mr Fleck able to hang himself with a sock? Why was the light fitting that was in the cell able to hold the weight of Mr Fleck's body?

The light fitting in Mr Fleck's cell was Ministry of Justice National Offender Management Service approved standard cell light fitting. I have made further comment on this in Section 7.4 of my report.

6. When was Mr Fleck last seen alive? How long it was before he was cut down and before CPR was administered? Was a defibrillator used while Mr Fleck was still in the prison?

The last conversation check with Mr Fleck was recorded at 19:20 on Sunday 03 March 2019 when Prison Officer O asked him if he was okay and Mr Fleck replied, "yeah."

Mr Fleck was last seen alive during an observation check by Prison Officer O on Sunday 03 March 2019 at 20:40, sitting up in bed in his cell.

He was found hanging at 21.05 by Prison Officer O. This Prison Officer and Prison Officer P entered Mr Fleck's cell at 21:07 and immediately supported Mr Fleck's weight and cut the ligature.

The Prison Officers checked for a pulse and when none was detected CPR was commenced immediately. Nurses arrived on the scene at 21:10 and observed officers applying CPR. A defibrillator was brought into the cell at 21:12 but did not advise a shock. CPR continued until Paramedics arrived at 21:38 and deployed another defibrillator which advised a shock at that time. A pulse was then detected by paramedic staff and CPR ceased.

7. Why were Mr Fleck's family not notified of the incident until 23:00 when he was first found shortly after 21:00?

Mr Fleck was discovered at 21:05 and left for hospital at approximately 22:00. It was 22:31 when contact with Mr Fleck's next of kin was attempted and 23:16 when the police contacted Maghaberry Prison to confirm that they had made contact with Mr Fleck's next of kin.

Standard 25 of the Prison Service Suicide and Self Harm Prevention Policy 2011 (updated October 2013) states that a Hot De-brief must take place following a

serious incident of self-harm or death in custody. Paragraph 8.5 instructs that the Duty Governor should ensure this takes place as soon after the incident has been brought under control as possible.

Paragraph 9.4 of the Prison Service Suicide and Self Harm Prevention Policy 2011 (updated October 2013) provides guidance on contacting next of kin in the event of a serious injury or death. This states that the Governor in charge or Duty Governor must inform, as a matter of urgency, the immediate family or next of kin or arrange for another appropriate person to do so. The policy also provides for the Governor to arrange for a family chaplain or local PSNI officer to inform the next of kin.

Paragraph 9 of Maghaberry Prison's Death in Custody Contingency Plan Number 51 (Reviewed October 2013) which gives effect to the Prison Service Suicide and Self Harm Prevention Policy, states that if an individual in custody has been moved to outside hospital and the medical opinion is that death is imminent or likely the Duty Governor should inform the next of kin as soon as possible.

It is important to note that when Mr Fleck left the prison, the paramedics had secured a pulse and were hopeful that they had revived Mr Fleck.

The Duty Governor held the Hot Debrief immediately after Mr Fleck left Maghaberry Prison for the hospital. The Hot Debrief is an important process for the facts of the incident to be established. This can then inform the content of the conversation with the individual's in custody's next of kin.

The first attempt to contact Mr Fleck's next of kin was made at 22:31, 8 minutes after the end of the Hot Debrief, and after Governor A had secured approval to contact the family. A further three attempts were made before the prison staff who had escorted Mr Fleck to hospital advised the prison's ECR that doctors had asked for his family to be contacted.

At this point the Duty Governor asked the police to make contact with Mr Fleck's next of kin. This was a satisfactory escalation by Governor A given the hospital had called for Mr Fleck's next of kin to be contacted.

The following Sections set out my findings under each investigation objective.

Section 6: Mr Fleck's Primary and Mental Health Needs

6.1: Clinical Review and healthcare needs

In this section I will examine if Mr Fleck's primary and mental health needs were appropriately managed from his committal until his transfer to hospital, including his medication management.

In prisons, clinical and mental healthcare must be provided, as in the community, in line with local and national policies and procedures. This section will consider policy and procedure and the overall effectiveness of clinical and mental healthcare provided to Mr Fleck in relation to his overall health.

The clinical care provided to Mr Fleck was considered by an independent clinical reviewer, Mr Terry Dutchburn, MSc, BA (Hons), RMN.

Mr Dutchburn was asked to consider the following:

- the appropriateness of clinical care provided to Mr Fleck and whether or not provision was in line with current clinically approved guidelines, local and national
- an opinion about whether or not the healthcare received in prison was equivalent to what would be provided in the community
- any learning which would assist either the Prison Service or healthcare providers in future
- any examples of good practice.

Mr Fleck had previous involvement with primary and mental health services during past committals to prison. He was not engaged with community addiction services or mental health services at the time of his death.

6.2 Medication Management

When Mr Fleck arrived at Maghaberry Prison he appeared intoxicated and exhibited drug seeking behaviour. He complained that he required Benzodiazepine medication and inferred that if he did not have both Diazepam and Temazepam he would be at risk of seizures.

Medication was withheld on Saturday 02 March 2019 by Nurse A due to concerns about potential interaction with unknown, illicit substances. The Nurse contacted the

Out of Hours (OOH) General Practitioner on Sunday 03 March 2019 regarding this, who confirmed that the Temazepam was safe to stop as Mr Fleck was already prescribed Diazepam, therefore he would not experience Benzodiazepine withdrawals and the risk of seizure would be minimal.

Clinical Outcome Withdrawal Scale (COWS) or Clinical Institute Withdrawal Scale (CIWA) checks were not completed because clinical observations did not indicate any drug withdrawal.

Mr Fleck received 7mg of Diazepam on the morning of Sunday 03 March 2019 following his SPAR Evo Review. He was then prescribed:

1. Diazepam 7mg on the evening of 03 March 2019.
2. Pregabalin 300mg on the morning and afternoon of 03 March 2019.
3. Quetiapine 25mg x2 on the morning of 03 March 2019.

Mr Fleck refused Propranolol 40 mg on the morning and evening of Sunday 03 March 2019. He was written up for Mirtazapine 45 mg but it would appear he did not receive it as the Medicine Administration Record states 'patient unavailable'. This was because Mr Fleck had already left the prison for the hospital.

In his report the Clinical Reviewer noted that a urine test had not been carried out at initial assessment on Saturday 02 March 2019 and in his view this would have indicated the use of an illicit substance. Urine testing is not currently a feature of the committal process. In Mr Fleck's case, the focus was keeping him safe on his first night in custody and this was the first concern for both Prison staff and Healthcare in Prisons staff. I am therefore content that Mr Fleck was managed in accordance with the operational procedures that were in place at the time of the introduction of SPAR Evo.

The Clinical Reviewer found that the use of Special Accommodation, Protective Clothing and 15-minute observations appeared appropriate and commensurate with the risk Mr Fleck displayed to keep him safe, particularly as a mental health assessment was not possible at a weekend.

The Clinical Reviewer goes on to say that "due to the uncertainty of whether Mr Fleck was under the influence of an illicit substance, withholding medication on Saturday 02 March was appropriate, and given his presentation on Sunday 03 March reintroducing his medication was acceptable."

6.3 Observations

Mr Fleck was reported to have appeared calmer after an uneventful night in Special Accommodation and Senior Officer C and Nurse D decided to move him to an ordinary cell in the committal house (Bann House) following his Care Plan Review on the morning of 03 March 2019. During this review the decision was taken to reduce Mr Fleck's observation intervals from every 15 minutes to every 60 minutes although in practice Mr Fleck was monitored every approximately 30 minutes.

The Clinical Reviewer noted in his report that although Mr Fleck's behaviour appeared to have improved, there is concern that reducing his observations to 60 minute intervals without a mental health assessment was premature. He goes on to comment, "transfer to Bann House appears acceptable, however remaining on more frequent observations may have been prudent until a mental health assessment had been completed."

It is important to remember that the new SPAR Evo methodology is to employ a person centred approach to keeping people safe while in custody. We know that Mr Fleck disliked being in Special Accommodation, under CCTV and that Mr Fleck was engaged in the care plan review on the morning of 03 March 2019. The decision to move Mr Fleck is supported by the Clinical Reviewer who concluded that, "given Mr Fleck's observed behaviour on Sunday 03 March 2019 there was no indication that he was at imminent risk of suicide or self-harm, or that taking his life could be predicted."

I am content that Mr Fleck's observations were appropriate as they were not reduced to 60 minutes. Given a review of SPAR Evo is pending I make no recommendation with regard to the move to 60 minute observations but await the outcome of the review.

Mr Fleck had no further contact with Healthcare in Prisons staff until an emergency Code Blue was called at 21:05. I discuss the Healthcare in Prison's emergency response to Mr Fleck later in my report.

6.4 Mental Heath

Nurse F conducted a mental health screening at 16:47 on 04 March 2019 (Monday). This was a desktop exercise whilst Mr Fleck was at outside hospital. Nurse F recorded that there was no documentary evidence in relation to historical major mental illness for Mr Fleck, but that Mr Fleck was known to Healthcare in Prison from previous committals and he had ongoing issues with substance misuse. Nurse F contacted Mr Fleck's Community Mental Health Team and recorded on EMIS that should Mr Fleck

survive his injuries and return to prison, he should be referred for an urgent mental health assessment.

In the opinion of the clinical reviewer, Mr Fleck was likely to have had an underlying diagnosis of Borderline Personality Disorder (BPD).[9] The RQIA *Review of services for vulnerable persons detained in Northern Ireland* (October 2021), notes that BPD is known to be highly prevalent within the prison setting. Both International and United Kingdom studies estimate that when diagnostic criteria are applied, approximately two thirds of the individuals in custody will meet the threshold for diagnosis of at least one type of personality disorder. This figure could likely be higher within Northern Ireland due to the conflict and intergenerational trauma which has been compounded by socio-economic deprivation across the region.

Mr Fleck attended hospital on 03 January 2019 and 19 February 2019 for treatment following acts of self-harm after arguments with his girlfriend. The clinical reviewer commented in his report that a diagnosis of BPD would be supported by Mr Fleck's attempts at self-harm which appear to have been impulsive acts following arguments in what appears to have been a volatile relationship.

The RQIA *Review of services for vulnerable persons detained in Northern Ireland* (October 2021) makes the following recommendation:

> *"Commissioners (currently the HSCB) and providers (SEHSCT) should work together to plan, commission and implement a therapeutic approach to personality disorder within the prison service. This should include the introduction of a specialist personality disorder service providing evidence-based treatment programmes. Commissioners (currently the HSCB) and providers (SEHSCT) should also work together with NIPS to consider the introduction of Psychologically Informed Planned Environments (PIPEs) to help improve the management of people with personality disorder".*

PIPEs are specifically designed environments, within a prison setting, which are staffed by Prison Officers who have received additional training on how to support those living with a personality disorder. They offer a safe and supportive environment through the adoption of a consistent approach of respective interaction between staff and individuals in custody and help individuals in custody maintain developments previously achieved through therapeutic intervention. While action is hampered by the Mental Capacity Act (NI) 2016 which does not recognise Personality Disorder, the Mental Health Strategy 2021-31[10] sets out a more helpful

[9] Borderline Personality Disorder (BPD), also known as Emotionally Unstable Personality Disorder (EUPD) is a mental health condition which manifests itself with unpredictable, impulsive behaviour, bouts of anger, difficulty in maintaining relationships, fluctuating mood, difficulty managing emotions and poor self-image.
[10] https://www.health-ni.gov.uk/publications/mental-health-strategy-2021-2031

approach to supporting these vulnerable individuals. Action 29 of the Mental Health Strategy sets out specialist interventions for those who need in and in particular notes the need to, 'enhance the provision of personality disorder services regionally through the formation of a Personality Disorder Managed Care Network.' Such a network could assist with the diagnosis and support of Personality Disorder and increase understanding of and support for individuals such as Mr Fleck.

Although Mr Fleck was in custody for a short time before he was taken to hospital, his story is all too common among the prison population and for this reason, I fully endorse the recommendation from the RQIA.

In line with National Institute for Health and Care Excellence (NICE) Guidance 57 and 66, the Trust's Mental Health Team in Maghaberry Prison piloted a Mental Health Face-to-Face Triage Tool for all new committals. This was following a review of Hydebank Wood College by the RQIA in 2019 and was launched in Maghaberry Prison in October 2020. Piloting this tool allowed the desktop paper exercise of a 'mental health screen' to transform into a face-to-face assessment with a mental health professional for every new committal.

I am pleased to report that the Mental Health Face-to-Face Triage Tool is now part of the committal assessment and is being used on both Maghaberry Prison and Hydebank Wood College sites. However at the time of Mr Fleck's committal, mental health services did not operate in Maghaberry Prison at weekends. I note that 7 day working for the Mental Health Team in Maghaberry Prison officially launched in October 2020 resources permitting, following a successful pilot. This is a welcome and important change and one that is recommended across all prison establishments by the RQIA:

> *"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 prion sites".*

6.5 Findings regarding Mr Fleck's Primary and Mental Health Needs

I am satisfied that Mr Fleck's physical and mental health needs were appropriately managed.

Mr Fleck's family asked about his medication. I can confirm that he received his medication on the morning of Sunday 03 March 2019. While he obviously wanted to receive his medication earlier than this, the decision to delay delivery was founded

on a concern about him having consumed other drugs which could have adverse effects should there be interaction with his medication. However, the lack of firm evidence of other drugs having been consumed could mean that he and, in some instances, other individuals in custody, would be denied required medication. However, in this instance steps were taken to ensure that this did not put Mr Fleck at risk of withdrawal.

In relation to the care provided to Mr Fleck, and others suspected of being under the influence of illicit substances on committal, I understand the reasons why urine testing is not normal process and am satisfied that Mr Fleck received his medication when appropriate and supported by clinical opinion.

The Clinical Reviewer refers to the use of Clinical Opiate Withdrawal Scale (COWS) or Clinical Institute Withdrawal Scale (CIWA). I am satisfied that these were not completed as Mr Fleck was not displaying any signs of drug withdrawal. The risks of Benzodiazepine withdrawal were considered and assessed by the Committal Nurse and out of hours GP.

I note the Clinical Reviewers comments about the frequency of observations for Mr Fleck and despite a formal reduction in the frequency to every 60 minutes, in practice observations were carried out every 30 minutes approximately. What remains of concern to me, as I have said in other reports, is how root causes of behaviours are uncovered and past history both in prison and in other places applied to inform current care. I will discuss this further in Section 6.3.

Section 7: Mr Fleck and the Suicide and Self-Harm Prevention Policy

In this section I will examine if Mr Fleck was managed effectively in accordance with the Suicide and Self-Harm Prevention Policy (2011) (Updated 2013) and if the decision to remove Mr Fleck from Special Accommodation on 02 March 2019 and reduce his observations to 60 minutes was satisfactory and commensurate with the assessed risk. I will also identify any learnings which might contribute to the development of SPAR Evo.

7.1 SPAR Evolution

At the time of Mr Fleck's death, the prison was in the process of implementing their Supporting People at Risk Evolution process, known as SPAR Evo. In Section 6 I have set out how the policy was applied to Mr Fleck.

The older SPAR process had been rightly aimed at keeping individuals in custody safe. The new SPAR Evo focussed on moving procedures from being process driven to people centred so that procedures applied would take account of each individuals needs in a more productive and meaningful way. A number of limitations were noted in the older, process-driven SPAR process, including acknowledgement that:

- Observation cells and safety clothing had become the default with little real improvement for or focus on the subject of the decision
- The numbers of people placed on SPARs diluted the attention staff could devote to individuals given the numbers of individuals in custody on SPARs at any one time
- The procedure was paper-based with streamlined information held digitally meaning only the staff member holding the SPAR booklet had a full overview

Additionally, a number of recommendations had been made to the Prison Service regarding SPAR processes by my Office, in CJINI and serious incident reports.

In conjunction with colleagues from the Trust, the Prison Health and Well-Being Lead developed a new people-centred model, operational procedures, required documentation and ultimately a new IT solution incorporating mobile technology which would mean staff were more informed about individuals in their care. SPAR Evolution, the name reflecting how the process was evolving, was formally signed off between the Prison Service and the Trust on 05 April 2019. A staged roll-out was agreed across all prison sites completing in August 2020.

It is important to note some key features of SPAR Evo which are distinct from those applied previously during a SPAR:

- **The multi-disciplinary approach** is designed to be managed with the person at the centre. While SPARs were commended for multi-disciplinary case conferences the important shift was the person-centred approach, alongside meaningful conversations.

- **The use of a *Concern***. The older SPAR process required a Prison Officer and Mental Health team member to open the SPAR. SPAR Evo allows anyone to raise a concern including staff, other individuals in custody and family members. When raising a concern a wide range of issues are now considered, as opposed to a checklist of issues, including background and history, what the individual is saying about their situation, asking about protective factors and suicide, consideration of contributory risks and making a determination about the degree or level of risk.

- **Assessing risk.** The older SPAR process had simply assessed an individual as being either at risk or not, requiring a SPAR or not. SPAR Evo, taking the broader and person-centre approach, offers 3 possible outcomes flowing from the Concern Form:

  - No apparent risk: requires no further action at the point in time when the Concern Form is completed but importantly a formal record is in place of the discussion, what issues were considered and how the determination of no apparent risk was reached. This record did not exist under the older SPAR process

  - No apparent risk with referral or other action: no immediate risk of suicide or self-harm but some additional support during the time of crisis or distress is required. The IT solution allows for these referrals to be made without delay, for example to mental health or for bereavement support. This response means that an individual in custody does not have to move cells into an observation cell, as they might have had to under the older SPAR, nor do they have to wait for referrals to be made

  - At risk: a care plan is put in place based on need and designed to address the root cause of the distress or crisis and support the individual in custody through it. As far as possible, individuals remain in their own cell and carry on with activities with the focus on engagement and contact in a meaningful way. This is a different focus from the older SPAR which would have placed the individual in custody into an observation cell or maintained them in their own cell but without normal activities.

- **A new IT solution.** Concerns are opened on a tablet on which the full history is available to the person completing the form. Colour coding allows staff to interpret information swiftly and include this in their considerations.

While the new SPAR Evo has yet to be evaluated the shift in emphasis is obvious. I consider this to be a significant and important development for supporting individuals in custody in a more human, and therefore likely to be more effective, way. 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 and the opportunity to make essential and informed refinements is restricted. I therefore endorse the RQIA report recommendation for an external review of the SPAR Evolution approach and

emphasise the urgency of this evaluation being completed. The RQIA recommendation currently is priority 3 meaning it should be completed within 18 months of the publication of the report (October 2021).

Recommendation 1 – SPAR Evolution Review

The Prisoner Ombudsman welcomes the commissioning of an external review of SPAR Evo as recommended in the Regulation and Quality Improvement Agency (RQIA) review of the Care of Vulnerable Persons Detained in NI Prisons (2021) and recommends that a copy be sent to the Prisoner Ombudsman on completion.

7.2 Special Accommodation and Observation Intervals

Prison Officers observed Mr Fleck at 15 minute intervals for the duration of his stay in Quoile House during the afternoon and night of Saturday 02 March 2019 until his move to Bann House on the morning of Sunday 03 March 2019. He was dressed in Protective Clothing and had very little with him in his cell.

Mr Fleck did not like being in Special Accommodation and I can understand that being observed by a CCTV camera in your cell every 15 minutes may have felt intrusive. It is documented in the Log Book that Mr Fleck blocked the CCTV camera in his cell for the majority of his time in Special Accommodation. Unfortunately CCTV footage from Mr Fleck's cell could not be recovered as part of this investigation because of a technical issue with the recordings, so this could not be corroborated.

Mr Fleck's observation intervals were reduced from every 15 minutes to every 60 minutes at his SPAR Evo review on Sunday 03 March 2019. Mr Fleck engaged in his review meeting and the Trust's Significant Event Audit Report[11] records that Mr Fleck, "was very settled and laughed off any suggestion that he was suicidal."

The Clinical Reviewer recommended that staff should be directed not to reduce observation frequency for individuals in custody at risk of suicide or self-harm until a mental health assessment has been completed. The Mental Health Team were not represented at Mr Fleck's SPAR Evo review meeting, given that is was a Sunday and,

[11] A Significant Event Audit Report is a Level One internal review of a Serious Adverse Incident that occurs in healthcare in line with the Regional Health and Social Care Procedure for the Reporting and Follow Up of Serious Adverse Incidents v1.1 2016.

at that time, this team did not operate at weekends in Maghaberry Prison. It is my understanding that mental health staff now routinely attend SPAR Evo Review meetings throughout the full 7-day week and conduct an in-person mental health triage as part of the committal process. I applaud the expansion of this much needed service and am satisfied that the recommendation from Mr Dutchburn does not need to be implemented at this time.

7.3 Cell Sharing Risk Assessments

The Suicide and Self Harm Prevention Policy 2011 (updated 2013) states that if an individual in custody is:

> *"deemed to be at risk of self-harm they should be allocated a cell in an environment where the risks posed can be adequately managed. This may require the need for doubling up with another prisoner. In such instances, the Cell Sharing Risk Assessment forms must be reviewed."*

Mr Fleck's Cell Sharing Risk Assessment was completed as part of his committal process on Saturday 02 March 2019. Mr Fleck stated at that time that he would attack any one that he was doubled with. There is no evidence to suggest that Mr Fleck's Cell Sharing Risk Assessment was revisited as part of his move to Bann House and there is no reference to it in his SPAR Evo documentation which leads me to believe that it wasn't considered as a possible protective factor for Mr Fleck in his move to Bann House.

7.4 Fabric Checks and Cell Compacts

In accordance with Maghaberry Prison's Governor's Order 3-10, fabric checks must be conducted on a daily basis and particular attention must be paid to fittings and ceilings. Any damage must be noted and reported for repair. The Class Officer's Journal for Bann Landings 1 and 2 record that cell structures were checked at 09:00 on Sunday 03 March 2019.

The light fitting in Bann 2 Cell 13 was a Ministry of Justice National Offender Management Service approved standard cell light fitting. A different specification is used in Special Accommodation. Mr Fleck had been reassessed as no longer needing to be monitored in Special Accommodation and he was instead monitored while remaining in a standard cell.

In addition to fabric checks, when an individual in custody is allocated a new cell a Cell Compact Form should be completed and held in the individual's in custody wing file. Amongst other things, this should also record the presentation of the cell. Mr

Flecks Wing File for Bann House did include a Cell Compact Report and although it was signed, it was not fully completed and did not record the condition of the cell or light fitting. It is therefore impossible to say if the light fitting in Bann 2 Cell 13 was damaged prior to Mr Fleck's occupancy.

I raise this as a particular issue as another individual in custody appeared to use the same methodology to hang himself some months previously. The risk that this can happen even when someone is being managed on a SPAR Evo should be brought to the attention of all staff and the importance of fabric checks in these circumstances underlined. The Prison Service should remind staff that a cell compact form is to be fully completed for each cell move and a copy placed on the individual in custody's residential file. This is a recommendation from a previous report and one which I will keep under review.

7.5 Staff Engagement

Mr Fleck was committed to Maghaberry Prison at the weekend when there is a reduced regime. This meant that he spent a considerable amount of time in his cell, under regular observation by landing staff.

My investigator reviewed the SPAR Evo documentation for Mr Fleck. On 02 and 03 March 2019, staff recorded regular attempts at engagement with Mr Fleck, known as Conversation checks[12] under the old SPAR process and contact intervals under the SPAR Evo process. I query the length and intent of some of these, remembering the person-centred approach of SPAR Evo and considering Mr Fleck was accommodated in a single cell. I acknowledge that significant time has passed since the introduction of SPAR Evo and I understand that the new process has now embedded well and that more meaningful conversations occur naturally during contact intervals.

Senior Officer C spent a great deal of the morning on Sunday 03 March 2019 engaging with Mr Fleck and evidenced a thorough attempt to understand Mr Fleck's behaviours in the context of his circumstances. This is documented well and it should be noted that Mr Fleck appeared much more settled after a period of engagement with Senior Officer C.

Under SPAR Evo, which has now been fully implemented across the prison sites, observations are variable and personalised to the individual and Special Accommodation is not the default response when supporting individuals at risk. Greater emphasis is placed on encouraging individuals in custody to spend as much time out of their cell engaging with others as possible, as well as exploring activity, accommodation, education, friends/family and mental health input where required.

[12] Conversation checks are a type of observation check when an officer is required to engage the individual in custody in a meaningful conversation.

This does not come without challenges for the Prison Service but is key in encouraging individuals at risk to engage and feel empowered and supported in their individualised care plan.

With SPAR Evo a new system of handovers form a key part of an individual in custody's care plan. These consist of 4 'Care Plan Reports' written up by staff engaging with individuals in custody deemed 'At Risk'. These are written up digitally on the PRISM system at 4 key times over a 24 hour period i.e. after morning regime, after afternoon regime, after evening association, and after night shift. Senior Officers are then automatically alerted on PRISM to perform a management check of the reports and observation logs, if applicable as these are no longer as prescriptive as they were under SPAR.

This method encourages real engagement with the person in crisis, assists in staff understanding a person's root causes or triggers whilst ensuring there is adequate information to hand over to new staff at key times of the day.

The Clinical Reviewer commented in his report that the Prison Service and the Trust should consider introducing a clear timescale for the completion of a SPAR Evo assessment following the completion of a concern form. Now that SPAR Evo has been implemented across the Prison Service in a digital form, I am satisfied that technology and processes are in place to allow staff to conduct a SPAR Evo assessment at the earliest opportunity following receipt of a Concern Form.

7.6 Findings in relation to Suicide and Self-harm Policy & Procedure

Mr Fleck was managed under SPAR Evo in the very early stages of its roll out in Maghaberry Prison in March 2019. There is evidence of good practice, such as the Senior Officer's engagement with Mr Fleck on the morning of 03 March 2019, as well as significant room for improvement, such as adequate conversation checks and person-centred approaches.

I appreciate that there has been significant progress on SPAR Evo since Mr Fleck's death however it is important that I am provided with assurance that the issues identified have been reflected in the operation of the SPAR Evo operating procedures. I await a copy of that evaluation, as recommended by my office and RQIA which will be the subject of external review. I make the following recommendations:

Recommendation 2 – Improving recording of personal triggers to self-harm

That the Prison Service and South Eastern Health and Social Care Trust monitor both SPAR Evo and risk sharing information to establish whether personal triggers leading to self-harm are recorded and if improvements could be made.

Recommendation 3- SPAR Evolution training
That the Prison Service ensure a programme of regular refresher training is provided to all relevant staff as and when required to ensure the integrity of the SPAR Evo approach.

Section 8: Response to next of kin calls

8.1 Response to Mrs Fleck's telephone call of 03 March 2019

I recognise that the days immediately after someone is admitted into custody can be worrying for a family. It is important therefore that any family contact with the Prison Service is carefully recorded so families can be reassured that their concerns have been noted. In this section I will consider if the response to Mrs Fleck's telephone call to the prison on 03 March 2019 was appropriate.

Telephone calls from concerned relatives are received, during office hours, by the prison switchboard and outside of office hours by the ECR. Details of the caller and the concern is recoded on a Safer Custody Call Log. The concern should then be shared with the relevant residential staff, who should record any action taken, and a copy of the Safer Custody Call Log should be shared with the PSST for any potential follow up action. A record of any follow up action should also be made.

My investigation did not find any record of Mrs Fleck's telephone call of 03 March 2019. This means that the investigation into the handling of the call is limited.

The investigation has been unable to verify:

- The date and time of Mrs Fleck's telephone call
- The identity of the Prison Officer in the ECR who received the call
- The content of the concern raised by Mrs Fleck
- The date and time of the follow up call to Bann House
- The identity of the officer in ECR who contacted Bann House

Issues with record keeping generally have been a recurring theme arising from death in custody investigations and I again underline to the Prison Service the importance of making timely records of all relevant information and the requirement for this information to be appropriately retained.

My investigation was able to establish that action had been taken as a result of Mrs Fleck's telephone call. Landing staff recalled at interview that they were notified by the ECR that Mr Fleck's mother had contacted the prison and they offered Mr Fleck a telephone call to contact her on the afternoon of 03 March 2019. Mr Fleck chose to use the call to contact his partner.

Landing staff did not make a record of the message received from the ECR and Mr Flecks SPAR Evo Log records the following:

> 16.25 Given an additional committal phone. Call to friend
> 16.30 Relocked in cell after committal phone call

It is important to note that because Mr Fleck had already been identified as someone who was at risk, Mrs Fleck's concern would not have changed the nature of the care that Mr Fleck received whilst in custody. This is because he was already being managed under the SPAR Evo operating procedures as someone who was at risk. Had Mr Fleck not been identified as someone at risk, then staff have the opportunity to open a Concern Form when a concern is raised. This can be as a result of a concern from a relative making contact with the prison, such as Mrs Fleck did. The Concern Form and risk assessment which follows, fall under the SPAR Evo operating procedures and allow for a clear pathway, using the prison computer system (PRISM) to ensure that concerns are recorded, assessed and any relevant action taken if required.

I make the following recommendation:

Recommendation 4 – Recording and responding to family concerns

That the Prison Service reinforce the importance of family concerns to all staff to ensure that family concerns are appropriately recorded and appropriate follow up action is taken, including notifying Healthcare In Prisons if a concern about mental health is raised.

Section 9: Responses to the Incident

In this section I will determine if the responses by the Prison Service and the Trust when Mr Fleck was found unresponsive were conducted in line with the relevant guidance.

I have examined the serious adverse incident response against relevant Standard Operating Procedures and am content that in the case of Mr Fleck, due process was followed.

9.1 Incident response

During the course of my investigation I have reviewed all relevant CCTV, Body Worn Video Camera footage, documentary evidence and relevant policies.

Prison Officer O lifted the flap of Cell 13, Bann 2 at 21:05 on Sunday 03 March 2019 to conduct an observation for Mr Fleck's SPAR Evo care plan and found him hanging from the light fitting. In under two minutes, Prison Officer O had called for assistance, accessed their emergency key pouch, entered the cell with Prison Officer P, lifted Mr Fleck up supporting his weight allowing the ligature to be cut in a safe and controlled manner, and commenced CPR. Senior Officer E was on the scene within two minutes of the call for assistance, and immediately radioed for an ambulance. Nurse C and Nurse E arrived at the cell in under 4 minutes.

The Nurses and Prison Officers administered continual CPR to Mr Fleck until paramedics arrived in the cell at 21:39. During this time a defibrillator was deployed, but advised not to shock. The paramedics used a further defibrillator which did advise a shock. A pulse was secured and Mr Fleck was stabilised enough to transport him to the hospital.

Both nurses had received life support training within the last 12 months. Nurse C had received Intermediate Life Support training and Nurse E was trained in Basic Life Support.

The Clinical Reviewer stated that the emergency response from Healthcare in Prisons staff "appears to have been well delivered in line with Resuscitation Council guidelines," and that "the care offered to Mr Fleck at Maghaberry Prison by healthcare staff was of a reasonable standard and equivalent to the care he would have received in the community."

I am satisfied that the Prison Officers on the scene responded to the incident with immediacy and in line with relevant guidance and they should be commended for their efforts, along with the responding Trust staff.

9.2 Post Incident

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. As part of my investigation I have reviewed all evidence relevant to the Hot and Cold Debriefs.

A Hot Debrief should take place as soon after the incident as possible and involve all staff closely involved with the incident where this is feasible. The purpose of a Hot Debrief 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 Hot Debrief was held at 22:10, on 03 March 2019 immediately following Mr Fleck's departure to hospital. The incident response was discussed and effort was made to ensure that all procedures such as preserving evidence and sealing the cell was adhered to. There was a discrepancy over the Healthcare in Prison's access to the cell following Mr Fleck's departure to hospital, where Nurse C and Nurse E requested access to clean up their equipment and this was denied by the Duty Governor on the grounds that the cell and contents needed to be preserved. I note that this issue was followed up at the Cold Debrief and clarification was given to Healthcare in Prison's staff for future reference.

Prison Officer O and Prison Officer P were stood down from duty and facilitated with additional leave. Nurse C and Nurse E completed their medical rounds of the prison. Nurse E was visibly upset at the Hot Debrief. All staff were informed of support services available to them.

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.

The Cold Debrief was held on Thursday 04 April 2019, approximately 1 calendar month after the incident on Sunday 03 March 2019. I note guidance states that the Cold Debrief is expected to take place within 14 days and I would stress the importance of adhering to this, given the importance of providing an opportunity to allow staff involved to reflect on the events in a supportive environment as well as discussing any lessons learned.

I also note that the Cold Debrief was not attended by all staff involved in the incident. Debriefs, both Hot and Cold, are an important and necessary part of any

adverse incident and I stress the importance of full attendance. Any staff that are unable to attend should be followed up with appropriately.

9.3 Liaison with Mr Fleck's Family

In this section I will assess if the Prison Service liaison with Mr Fleck's family immediately following the incident was adequate.

The Hot Debrief concluded at approximately 22.25 on 03 March 2019. The next of kin contact details were located and the Duty Governor, Governor A, then proceeded to secure approval from the Senior Governor, Governor B, to contact Mr Fleck's next of kin. This was granted and the Duty Governor attempted contact with Mr Fleck's next of kin on their landline at 22:31 and 22:41, and on their mobile phone at 22:32 and 22:42. These attempts were unsuccessful.

Shortly after the final attempt to contact Mr Fleck's next of kin, Prison Officers on duty as escort staff at the hospital with Mr Fleck made contact with the Duty Governor, Governor A, to relay a message from hospital staff that they required the next of kin to be contacted. Governor A then contacted the PSNI and requested that they attend the home of Mr Fleck's next of kin to inform them of the situation. The PSNI confirmed that they had made contact at 23:16.

Whilst I understand that Mr Fleck's next of kin may have felt that they were not contacted at the earliest opportunity, it is important to recognise that CPR was being performed on Mr Fleck for approximately 60 minutes until he was able to be transferred to the hospital. At this point the incident was being treated as an incident of serious self-harm. Additionally, the Duty Governor, Governor A had a responsibility to hold a Hot Debrief with those involved as soon as possible after the incident. This debrief provided Governor A with an opportunity to better understand the full details of the incident. Governor A sought approval from the Senior Governor on call that evening to confirm that a telephone call to Mr Fleck's next of kin was appropriate. Given that this was a short conversation I am satisfied that it did not cause significant delay to the family. Governor A then made four attempts to contact Mr Fleck's next of kin, all of which were unsuccessful. In order to avoid delay it was appropriate for the Prison Service to seek assistance from the PSNI to notify Mr Fleck's next of kin. I am satisfied that the Prison Service followed procedure and did not encounter significant delay.

Section 10: Conclusions

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

10.1 Establish the circumstances and events surrounding the death of Mr Fleck, including the care provided by the Prison Service.

I have reported in detail the circumstances surrounding the death of Mr Fleck in Section 4 of my report.

10.2 Examine any relevant healthcare issues and assess clinical care provided by the Trust.

The clinical reviewer Mr Terry Dutchburn MSc, BA (Hons), RMN reported that in his professional opinion, the care offered to Mr Fleck at Maghaberry Prison by Trust staff was of a standard representing equivalence of care he would have received in the community.

10.3 Examine whether any changes in Prison Service or Trust operational methods, policy, and practice or management arrangements could help prevent a similar death in future.

In the course of the investigation I have concluded that there is some improvement still to be made in relation to SPAR Evo and I have made 4 recommendations in this report in relation to this. All but recommendation 2 have been accepted by the Prison Service and the Trust.

I note the positive improvements to existing policy and practice in Section 7.5.

10.4 Ensure that the individual in custody's family have an opportunity to raise any concerns they may have, and take these into account in the investigation.

I have addressed, where possible the concerns raised by Mr Fleck's family and acknowledge that his family raised valid concerns about how their son's particular needs were addressed in custody.

I listed in Section 5.1 the questions that the family asked me to address during the course of my investigation and the findings are summarised in Section 6.1 – 6.5.

10.5 Assist the Coroner's investigative obligation under Article 2 of the European Convention of Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing exposed, any commendable practice is identified and any lessons from the death are learned.

It is commendable that the Prison Service have implemented their SPAR Evo operating procedures. This appears to be a much improved process which has the individual's best interests and autonomy at its core, however I await the findings of the external review and recommendations as set out in Section 7.

It is commendable that the Trust now operate an improved mental health service within Maghaberry Prison, with extended operating hours and increased individual contact.

My investigation has as far as possible shed light on the full facts of this case and I will ensure full disclosure of our materials to the Coroner.

Appendix 1: Terms of Reference for Prisoner Ombudsman investigations into Deaths in 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) replaced with South Eastern Health and Social Care Trust as the healthcare provider in prisons, 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 this 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.

Appendix 2: Terms of Reference for a clinical review of healthcare in the case of Mr James Fleck

To review the medical and healthcare records of Mr James Fleck, to produce a report giving an expert opinion and advice regarding:
• Mr Fleck's health care and mental health needs and how they were managed, including if there were any risks that could have been identified; and • Any learning points for the Northern Ireland Prison Service (the Prison Service) and the South Eastern Health and Social Care Trust (the Trust).

APPENDIX 3: Summary of dates and times referenced in this report

	03 January 2019
	Mr Fleck attended hospital for treatment following an act of self-harm after an argument with his girlfriend.
	19 February 2019
	Mr Fleck attended hospital for treatment following an act of self-harm after an argument with his girlfriend.
	02 March 2019
	Mr Fleck was transferred from Police Service of Northern Ireland's (PSNI) custody into the care of the Prisoner Escort and Court Custody Service (PECCS) at Laganside Courts.
14:00	Mr Fleck arrived at Maghaberry Prison just before 14:00.
14:50	Mr Fleck was moved into a single holding room. This was because he began to remove his clothes and threatened to use them to make a ligature.
14:54	Mr Fleck's clothing was returned to him, he left the holding room and was escorted to the healthcare room for a committal assessment with Nurse A.
14:57	Egton Medical Information System (EMIS) notes completed record that Mr Fleck appeared under the influence of unknown substances and was pre-occupied with medications. Nurse A was unable to assess him for Benzodiazepine withdrawal due to his "aggressive and threatening" behaviour and withheld Mr Fleck's prescription medication because of concerns about what he may have already taken.
	Mr Fleck was escorted to a single holding room where he removed his clothes and attempted to tie a ligature around his neck. His clothing was again removed from the cell by Prison Officers for his own safety.
16:00	Senior Officer A entered the holding room and attempted to de-escalate the situation.
16:08	Mr Fleck's clothes were returned to him and he was escorted outside for a cigarette.
16:15	He returned to reception and he apologised to Prison Officer A for his behaviour.
16:17	Mr Fleck participated in a committal interview with Prison Officer A.
16:35	Mr Fleck made a committal telephone call and spoke to his partner. They discussed his solicitor, his bail application and his possible sentence of 3 to 4 years. Mr Fleck appeared disappointed that his partner hadn't yet booked a visit to see him and told her not to contact him. The call ended.
16:50	As is the process at committal, Mr Fleck participated in a full body search which was conducted by Prison Officer A and Prison Officer B. Nothing of note was found during the search.

17:05	The Duty Governor, Governor A, authorised the use of Special Accommodation and Protective Clothing.
	An immediate **Keep Safe** plan was put in place by staff who agreed that Mr Fleck would be observed every 15 minutes, both in person and by CCTV monitoring.
17:25	Prison Officers B, C and D escorted Mr Fleck from reception to Quoile House.
17:32	Shortly after arriving in Quoile House, a discipline alarm was raised and Mr Fleck was held under close escort and then under restraint using a procedure called Control and Restraint, close to the door of Cell 30 on Landing 4. This was because he became noncompliant and resisted being placed in Special Accommodation.
17:35	Prison Officer's E, F and G from the prison's Dedicated Search Team (DST) arrived in Quoile House. They relocated Mr Fleck from the landing into Special Accommodation and placed him in Protective clothing.
17:40	DST staff left and Mr Fleck was locked in his cell (Landing 4, Cell 30). Senior Officer B recorded that Mr Fleck presented as very agitated and continued to issue verbal threats to staff.
17:39 – 18:47	Mr Fleck activated his cell bell twelve times between 17:39 and 18:47.
17:40:17	Mr Fleck made a call to the Samaritans lasting 12 seconds.
17:41:09	Mr Fleck made a call to the Samaritans lasting 7 seconds.
17:42	At 17:42 Nurse B attempted to talk to Mr Fleck at the cell door following the Control and Restraint incident.
17:45	Mr Fleck's SPAR Evo log book records "given tea meal and cigarettes," by Prison Officer H.
23:00	Mr Fleck retired to bed with no complaints reported to landing staff.
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07:26	Mr Fleck's SPAR Evo log book records "Prisoner had a quiet night, no issues expressed." by Night Custody Officer I
08:03	CCTV records show that Prison Officer J talked to Mr Fleck at his cell door. The SPAR Evo log records that Mr Fleck refused to engage with the Prison Officer.
08:43	Prison Officers from the DST entered Mr Fleck's cell and spent approximately 3 minutes searching it. This was because there was suspicion that he was in possession of drugs. Nothing was found.
08:47	Senior Officer C talked with Mr Fleck for approximately 5 minutes through the flap in the cell door. During this conversation he is recorded as requesting medication, to which he was advised that he could speak with a nurse.
08:56	Senior Officer C opened the cell door and gave Mr Fleck some cigarettes. Senior Officer C offered him a cup of tea but he declined and requested a drink of water. Senior Officer C remained talking to him for a further 3 minutes.
09:06	Two officers entered Mr Fleck's cell to supervise him brushing his teeth, and give him a drink of water and toilet roll.

09:29	Senior Officer C and Prison Officer K opened the cell door and talked with Mr Fleck for approximately 5 minutes. The SPAR Evo Log records that he was offered some breakfast and told that the nurse would be around shortly to see him.
09:38	Mr Fleck was given some breakfast in his cell.
09:48	Mr Fleck is recorded as having thrown his breakfast around his cell.
10:11 – 10:20	Senior Officer C and 2 other staff spoke to Mr Fleck at the door of his cell. The Senior Officer advised that if he had an issue then he should talk to the staff who would attempt to get the issue resolved. Mr Fleck agreed and apologised for his actions.
10:35 – 10:51	Senior Officer C chaired a SPAR Evo review with Mr Fleck in his cell. Prison Officer K and Nurse D also attended.
10:54	Nurse D administered 7mg of diazepam to Mr Fleck in his cell and conducted observations of him.
11:30	Mr Fleck left Quoile House and was escorted to Bann House by Senior Officer C and Prison Officer K.
11:42	Mr Fleck arrived at Bann House.
11:56 – 12:04	Mr Fleck attended a Comprehensive Committal Assessment with Nurse A in the healthcare room of Bann House.
	Bann House Class Office, received a telephone call from the Emergency Control Room (ECR) to say that Mr Fleck's mother had contacted the prison.
14:10	Mr Fleck was offered a committal telephone call to contact his mother. He declined the offer.
14:10 – 15:40	Mr Fleck was offered the use of the Bann House exercise yard in the afternoon which he accepted.
15:40	Mr Fleck was offered an additional committal telephone call to contact his mother.
16:26 – 16:31	Mr Fleck chose to use his additional committal call to speak with his partner.
16:31	Mr Fleck was locked in his cell, which is the normal regime at weekends.
19:20	The last conversation check with Mr Fleck recorded Prison Officer O asked him if he was okay and Mr Fleck replied, "yeah." Prison Officer O recorded in the SPAR Evo log that Mr Fleck appeared calm and relaxed.
19:46	A Prison Officer observed Mr Fleck lying awake on the top bunk.
20:12	Records show Mr Fleck was observed in bed with the TV on.
20:40	Mr Fleck was sitting up in bed.
21:05	Prison Officer O checked Mr Fleck again. When Prison Officer O lifted the flap he saw Mr Fleck unresponsive. He immediately sent an urgent Code Blue message, the emergency radio code for an unconscious prisoner, over the radio. A colleague from Bann landings 3 and 4, Prison Officer P, responded immediately.
21:07	Prison Officer O broke open his emergency key pouch and unlocked the cell door. Prison Officer's O and P entered the cell, lowered Mr Fleck onto the cell floor, checked for a pulse, none was found and Cardio Pulmonary Resuscitation (CPR) was commenced immediately.

21:08	Senior Officer E arrived on the landing, requested an emergency ambulance and entered the cell.
21:09	Senior Officer E left the cell.
21:10	Nurse C arrived at the cell door followed by Nurse E. Senior Officer E returned to the cell.
21:11	Senior Officer E left the cell.
21:12	Senior Officer E returned to the cell with a small red bag containing the defibrillator.
21:28	Prison Officer Q and Prison Officer R arrived on the landing. Prison Officer Q kept a log of events from the cell door.
21:38	Two paramedics arrived in the cell. They took the lead in the resuscitation effort and were assisted by the Prison Officers and nurses who were present. The paramedics administered a cardio shock and shortly afterwards a pulse was detected.
21:58	Mr Fleck was carried out of his cell on a stretcher by two paramedics.
22:10	Mr Fleck left the prison estate and was taken by ambulance to Craigavon Area Hospital.
22:38	Mr Fleck arrived at Craigavon Area Hospital.
22:10	The Duty Governor, Governor A, held a Hot Debrief for the staff involved in the incident in the Class Office of Bann House. Senior Officer E, Prison Officer O, Prison Officer P, Nurse C and Nurse E also attended.
22:21	CCTV confirmed that Mr Fleck's cell was sealed with an isolation bar.
22:23	Hot Debrief ended.
	Governor A requested approval to notify Mr Fleck's next of kin that he had been taken to hospital. This was granted by Governor B.
22:31	Governor A attempted unsuccessfully to contact Mr Fleck's next of kin by landline.
22:32	Governor A attempted unsuccessfully to contact Mr Fleck's next of kin by mobile.
22:41	Governor A attempted unsuccessfully to contact Mr Fleck's next of kin by landline.
22:42	Governor A attempted unsuccessfully to contact Mr Fleck's next of kin by mobile.
22:45	Prison staff who had escorted Mr Fleck to hospital advised the prison's ECR that doctors had asked for his family to be contacted. As Governor A had not been able to contact the next of kin directly they asked the police to attempt to make contact in order to avoid any further delay.
23:16	The police contacted Maghaberry Prison to confirm that they had made contact with Mr Fleck's next of kin.
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16:47	Nurse F conducted a mental health screening. This was a desktop exercise whilst Mr Fleck was at outside hospital.
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	Governor D attended the hospital and released Mr Fleck under Prison Rule 27.
	08 March 2019
21:40	Mr Fleck was declared deceased.
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	A Post Mortem was completed and recorded Mr Fleck's cause of death as pneumonia due to cerebral hypoxia due to hanging.
	04 April 2019
	A Cold Debrief was held and attended by Governor A, Governor B, Prisoner Safety and Support Governor, Governor C, Senior Officer E, Prison Officer O and Prison Officer P.