A synopsis of the report of an Independent Inquiry into the circumstances of an incident of concerted indiscipline and fire in Erne House, Maghaberry Prison on 26th April 2015

Inquiry team -

Jerry Spencer - Governing Governor HMP Risley (NOMS)

Bill Gallon - Governor Head of Residential HMP Kirkham (NOMS)

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1. Introduction

Outlined below is a synopsis of the independent inquiry into a fire in Erne House, Maghaberry Prison on 26th April 2015. The inquiry was commissioned by Sue McAllister, Director General of the Northern Ireland Prison Service on 4th December 2015, and undertaken by Jerry Spencer, Governing Governor HMP Risley (NOMS) and Bill Gallon, Governor of Residence & Services HMP Kirkham (NOMS).

In order to underpin the independence of this inquiry it is useful to offer background, knowledge and experience of the inquiry team, whilst also outlining what expert advice was in place for key strands of this inquiry.

2. Inquiry team

Jerry Spencer has been in command of HMP Risley for 4 years (Category C – roll 1115), prior to this he was Deputy Governor of HMP Liverpool for 4 years. Jerry has operated predominantly in the North West of England, joining HM Prison Service in 1988. He has served in a wide range of establishments, mainly in the male estate. He has undertaken a number of investigations throughout his career, is trained in the command of serious incidents and operated to Silver Commander on numerous occasions as Deputy Governor and Governor, some of which included the NOMS recognised Gold Command structure. He has never visited Northern Ireland before.

Bill Gallon has been Head of Residence and Services at HMP Kirkham (Category D- roll 650) for the past 18 months, prior to this he served as Functional Head of several departments at HMP Liverpool for 7 years. Bill has served in several prisons in the male estate in the North West of England, he joined HM Prison Service in 1991. He has assisted with and led investigations, is trained in the command of serious incidents and has acted in Silver and Bronze command roles. Bill has extensive experience within safer custody working closely with Coroners Officers and the Coroner of Liverpool. He has never visited Northern Ireland before.

Specialist advice was received by Adrian Parry who is a senior Health & Safety advisor in the North West Region of NOMS, the advice specifically related to fire safety.

3. Terms of Reference

INQUIRY INTO THE CIRCUMSTANCES OF AN INCIDENT OF CONCERTED INDISCIPLINE IN ERNE HOUSE, MAGHABERRY PRISON ON 26 APRIL 2015

On 26 April 2015 there was a period of concerted indiscipline in Erne House, Maghaberry Prison, which resulted in a fire and significant damage at this location.

The Report on an unannounced inspection of Maghaberry Prison (11 – 22 May 2015) made the following recommendation.

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

You are directed to inquire into this incident and to report your findings and recommendations to me.

You should establish the facts in respect of the circumstances of the incident, its causes, and the manner in which it was managed and resolved. You should make recommendations about how an incident of this type or a similar occurrence may be prevented, avoided or managed in the future.

Detailed consideration should be given to the current incident management arrangements, capability and training in the Northern Ireland Prison Service (NIPS), you should make recommendations that may improve the effectiveness and robustness of these processes in the case of a future incident.

NIPS Staff will be made available to support you, to ensure the effective conduct and completion of the inquiry.

You are to provide me with your final report by 31 December unless this timetable is revised with my agreement.

SUE McALLISTER

4. Executive Summary

The main emphasis of the inquiry focussed on the facts relating to the events of Sunday 26th April 2015, the cause of the concerted indiscipline which then resulted in the fire, its management and ultimate resolution, and what critical lessons can be learned in order to prevent reoccurrence. However, the inquiry was ultimately wider than initially anticipated due to the concerns which emerged regarding fire safety.

The interview strategy adopted was one of a "bottom up" approach. Three perpetrators initially gave their account of events and their reasons why they took such actions, whilst prisoners off each section of Erne House were interviewed in order to understand from their perspective how events unfolded and what their experiences of the fire were. Erne House staff were interviewed to gain an insight in terms of the events leading up to the fire on the Sunday, whilst also understanding how management of the incident directly impacted on their own actions during the weekend. The staff also gave a very useful overview of why they believed this incident was poorly managed.

Staff supporting the management of this incident were key to fully understand how contingency planning operated at the prison, clearly demonstrating some fundamental weaknesses in the overall management of incidents. Those interviewed included the lead intervention commander who was responsible for drawing up intervention and surrender plans, and critically the Erne House Senior Officer (SO) who was in control of the wing throughout the incident.

The inquiry focussed a relatively significant amount of its time on the fire safety element to the incident as well as a broader understanding of fire safety at Maghaberry Prison given the serious concerns that became apparent.

It was important to gain an independent view of the management of the incident, as well as a view of the potential causes to the incident, this was provided via an interview with the Chair of the Independent Monitoring Board (IMB), with contributions from 2 other IMB members.

Towards the end of the inquiry the Duty Director for the weekend of 25/26 April 2015 was interviewed, critically assisting in determining how long the intervention/surrender plans sat with the Duty Gold Commander (Sue McAllister). This interview provided an invaluable insight into the timeline of events. The Duty Director also provided a comprehensive overview of Gold Command arrangements and the current weaknesses in the system, including IT issues/glitches that did not help matters on the day of the incident.

Following this interview it was crucial to then interview the Duty Governor for the weekend in question in order to understand the rationale behind his actions, his decision making, his thought processes on a range of issues and why he believed the incident evolved to the point of a serious fire. The Duty Governor was subsequently re-interviewed after a further in depth review of the timelines gave cause for requiring further clarity on some key issues. On the second interview the Duty Governor was able to provide more information on the unsuccessful attempt at sending the intervention/surrender plans to Gold Command from his e mail account, and notably inaccurate entries in his Duty Governor report that he wrote shortly after the conclusion of the incident.

The Governing Governor was unable to be interviewed during this inquiry. However, the Governing Governor attended the prison on two occasions throughout the weekend of 25/26 April 2015, and to interview him would have been critical in terms of trying to understand why there were clear delays to the final resolution during the Sunday afternoon, and why such opportunities were not taken during his time as Silver Commander or in his discussions with the Duty Governor prior to his arrival at the prison. Finally the Director General was interviewed, this gave an insight into Gold Commander arrangements that were in place in April 2015, and clarified the critical timelines around when she actually received the intervention/surrender plans. The inquiry team reviewed CCTV footage of the full incident on 26th April 2015.

The main conclusion to be drawn from our inquiries clearly demonstrated that the fire that occurred in Erne House store at approximately 1537 hours on Sunday 26th April 2015, 2 hours and 41 minutes after the incident of concerted indiscipline was first reported to the

ECR, was wholly preventable. Many opportunities were presented during that afternoon that should have been taken by Silver Command to bring the incident to a resolution. Further opportunities were missed to take action which could have substantially prevented escalation of the incident and minimised risks. It was concluded that critical members of the Silver Command team displayed poor and reckless decision making.

This inquiry brings a key opportunity to draw significant learning from this incident across a broad range of issues at Maghaberry Prison as well as the Northern Ireland Prison Service. However, there are clear and significant risks to fire safety that need to be addressed urgently, in order to give the Director General and the 3 Governing Governors assurances that Health and Fire Safety is being managed appropriately, and that the corporate risk is mitigated accordingly.

We recognise much work has been completed since the inspection in May 2015, with the new Governor having to prioritise key issues from the inspection report prior to a revisit from the inspection team in January 2016. It is our sincere hope that this inquiry report will supplement key priorities for Maghaberry Prison and the wider service in 2016.

5. Overview of incident

A number of events occurred on Saturday 25th April 2015 on Erne House that led to, and were contributory to the acts of concerted indiscipline and fire on the Sunday. A false alarm (general) was sounded on Erne House during the late morning of Saturday 25th April 2015, this resulted in the whole wing being locked up. During this alarm a prisoner had to be restrained as he had refused to be locked in his cell, this prisoner was found to be one of the main protagonists to the events the following day. Further confrontations occurred throughout the rest of Saturday which ultimately resulted in a number of prisoners causing deliberate damage to their cells, as a consequence they breached prison rules, which ultimately meant that they had to be exercised separately the following day.

During the morning of 26th April 2015, the Duty Governor ultimately made the decision that the 11 prisoners involved in the acts of indiscipline the previous evening had to be exercised

separately from the rest of the prisoners on Erne House. Two exercise periods were then planned, one during the morning and the second over the lunch time period. The first exercise period (5 prisoners) was completed without incident. The second exercise period commenced at 1230 hours involving 6 of the 11 prisoners involved in the indiscipline.

At 1256 hours the Control Room at Maghaberry Prison received a call from an Officer on Erne House stating that the 6 prisoners were causing damage to the windows surrounding the exercise yard, making weapons and shields out of perspex (from broken windows) and being handed makeshift weapons via the prisoners who were located in their cells overlooking the yard. At some point shortly after this call a small fire was made in one of the corners of the exercise yard, this was quickly extinguished. NIFRS were not alerted to this fire.

Following an initial assessment by the Duty Governor, he brought together resources to deal with the incident in a swift manner. It was reported that by 1330 hours (34 minutes after the incident was first reported) that a team of 30 Control & Restraint (C&R) staff and 2 dog handlers were in full PPE ready to intervene. It was also reported that an intervention plan had been drawn up on a white board by the Security Senior Officer.

At approximately 1335 hours (39 minutes after the incident was first reported) the Duty Governor then contacted the Duty Director when it was clear that the 6 prisoners were not coming off the exercise yard and were "tooled" up (armed with makeshift weapons). The Duty Director felt that the Duty Governor had everything in place to deal with this incident with the exception of written intervention and surrender plans, he was surprised the plans were not already in place. At approximately 1345 hours the Duty Director spoke with Sue McAllister and appraised her of the situation at Maghaberry Prison, evidently she expressed surprise that the 6 prisoners were on the exercise yard at the same time and during a patrol period, the investigation team were equally surprised by this decision. She instructed the Duty Director to contact the Duty Governor and instruct him to open the Silver Command Suite, call the Governing Governor into the prison and forward intervention and surrender plans to her at the earliest opportunity.

At approximately 1408 hours prisoners on the exercise yard started a second fire in the centre of the yard. This fire had a number of broken perspex windows placed on the fire causing a large amount of black smoke. Further attempts were made by the FPO to extinguish the fire, however due to a low water pressure on Erne House the NIFRS were called to attend the scene at 1412 hours, they arrived at 1427 hours. By this stage the Silver Command Suite was operational (1400 hours) with key staff assisting the Duty Governor. The Governing Governor was en route and arrived in the establishment at 1439 hours, more or less 1 hour before prisoners set fire to Erne House store.

The Security Senior Officer sent the intervention/surrender plans to the Duty Governor at 1430 hours, the Duty Governor confirmed that he received the plans at 1430 hours, and stated to the inquiry team that he forwarded them immediately to Gold Command, further stating that the Duty Director had forwarded the plans on to the Gold Commander at 1454 hours, we found that this was not the case and that the Duty Governor had never forwarded the plans at this stage of the incident.

At 1435 hours, 1440 hours and 1446 hours 3 separate recorded requests were made to the Silver Command Suite for prisoners to surrender, it was noted by a number of staff and prisoners that the 6 prisoners on the exercise yard were waving a white flag with the clear intention of wanting to surrender. The Duty Governor was unable to explain satisfactorily why a surrender was not authorised from within the Silver Command Suite. As a consequence of this lack of action, the 6 prisoners then went onto break into a store adjoining the exercise yard at 1535 hours, this store held chemicals, bed sheets, toilet rolls and large quantities of other cleaning materials, the prisoners quickly set a fire to this store.
Just prior to the store being set on fire Gold Command was established in Belfast, at this point the Duty Director quickly realised that the intervention/surrender plans had not been sent by Silver Command, he alerted the Silver Command to this serious omission, this was quickly rectified as the plans were forwarded to Gold Command just after 1530 hours, these were then almost immediately sent to the Director General by email.

At 1538 hours a decision was taken to send teams of staff in full PPE to remove the prisoners from the exercise yard. A number of other prisoners located in cells above the

seat of the fire were evacuated to another part of Erne House whilst the NIFRS tackled the fire. A number of difficulties were encountered in gaining access to the fire, however it was fully extinguished by 1751 hours.

6. Summary

The fire that occurred in Erne House store at approximately 1537 hours on Sunday 26th April 2015, 2 hours and 41 minutes after the incident was first reported to the ECR, was wholly preventable. Numerous opportunities were presented throughout the afternoon to bring this incident to a conclusion, either through intervention, prevention or surrender. Exceptionally poor operational judgement from within the Silver Command Suite on Sunday 26th April 2015 on several occasions directly contributed to the final events that unfolded that afternoon.

Incident management is in a transitional phase at Maghaberry Prison. This is quantified by the fact that an incident with striking similarities 3 days earlier in another part of the prison was managed and resolved in a manner that is consistent with how incident management should occur, utilising the correct procedures between Silver and Gold Command in terms of intervention/surrender plans, albeit slower than would have been expected. Yet in a matter of days an, "old school" style of operational management/intervention was initially proposed by the Duty Governor to bring a clear act of concerted indiscipline amongst 6 prisoners on an exercise yard to an early resolution, bypassing revised systems that had appropriately and correctly been put in place. This, "old school" approach was rightly halted in its tracks by the Duty Director to the irritation of the Duty Governor. It could reasonably be argued that the new approach to incident management was initially resisted on this occasion, with consequences that no one could have foreseen at the outset, hence this incident must bring about the opportunity for much needed change.

The indirect causes of this incident spread wider than the direct actions taken on the day in question though. It is concluded that the severe restrictions to the regime that plagued the prison for many months prior to April 2015 due to exceptionally high staff absence levels,

was a pivotal reason in the indiscipline displayed by a small number of Erne House prisoners.

The lack of comprehensive, up to date incident management training for all managers from Senior Officer upwards is also a cause to why this incident developed in the manner it did. Had there been a consistent approach to incident management via a quality and robust training package, the resistance to move to a "new way of working" demonstrated on this day may well have been weakened if all other key personnel involved in the incident were clear of their revised responsibilities.

Through the actions taken by key operational staff there were no near fatalities to either prisoners or staff. That said prisoners understandably felt trapped in a dangerous environment with relatively little assurance from staff to ease their concerns for their safety. We can understand why some prisoners expressed real concern for their own safety that afternoon.

7. Main Recommendations

Undertake a root and branch review of incident management across the 3 prisons in Northern Ireland capturing shared learning with NOMS.

Introduce a comprehensive training programme/course that will deliver the shared learning from the root and branch review, the training programme should be devised and delivered by NIPS Operational Managers in conjunction with key NOMS personnel.

A full annual programme of contingency plan exercises should be established. These should be determined through a risk assessment and analysis of Maghaberry Prison's incidents and lead to a review of local contingency plans and the command structure. All key staff should be involved in these exercises.

Undertake an urgent and independent review of the corporate governance arrangements currently in place for Health and Fire Safety across NIPS, ensuring they are sufficiently

robust enough to give assurances that all statutory duties are effectively and efficiently discharged.

Undertake an immediate independent assessment of fire evacuation points in Erne house and other similarly constructed accommodation units at Maghaberry Prison. This assessment must ensure compliance with health and fire safety legislation (Department of Finance & Personnel Building Regulations 2012) to ensure there is compliance with the law.

Consider strengthening relationships and developing a memorandum of understanding with the police with a view to robust action being taken against those prisoners who commit acts of arson and criminal damage.

Jerry Spencer

Governing Governor

HMP Risley

January 2016