



Northern Ireland
Assembly

Committee for Justice

OFFICIAL REPORT (Hansard)

Report on Serious Self-harm by Sean Lynch
in Maghaberry Prison:
Prisoner Ombudsman for Northern Ireland

6 October 2016

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:

Mr Paul Frew (Chairperson)
Mrs Pam Cameron (Deputy Chairperson)
Mr Doug Beattie
Mr Roy Beggs
Mr Sammy Douglas
Mr Declan Kearney
Mr Trevor Lunn
Mr Pat Sheehan

Witnesses:

Mr Tom McGonigle Prisoner Ombudsman for Northern Ireland

The Chairperson (Mr Frew): With us is Tom McGonigle, the Prisoner Ombudsman for Northern Ireland. You are very welcome, Tom, as always. I advise you that the session is being recorded, and the Hansard report will be published on the Committee website. I invite you to open with a statement.

Mr Tom McGonigle (Prisoner Ombudsman for Northern Ireland): Thank you, Chair. Good afternoon, everybody. I welcome your interest in this disturbing case. I particularly welcome the fact that you have also referred the matter to the Health Committee. The South Eastern Health and Social Care Trust has referred to this as a landmark case, and, in my view, it is a perfect opportunity for some sort of joined-up government between the Department of Health and the Department of Justice. I hope that, if there is any learning to come from this case, it will improve things for mentally ill prisoners, through a joint approach between the two Departments and the two organisations involved. I propose to make some preliminary comments and then open it up for your comments and questions, if that is OK.

I think that context is important. I am aware of several mentally ill people who are in prison, and I am aware of some excellent work done by prison officers and nurses and doctors in the prisons to help them. I have spoken to prisoners who said that they would not be alive had they not been in prison; it was prison that kept them alive. Unfortunately for Mr Lynch, the interventions, in his case, were not sufficiently prompt to save him from serious self-harm.

It is worth noting that, in the UK context, the rate of self-harm and self-inflicted death in prison is something like eight times as high as it is in the community. Prison populations throughout the UK have very high rates of emotionally damaged people to deal with. I am aware of several other prisoners, particularly in Maghaberry, and also some women in Ash House, who are remanded for

psychiatric assessment. The courts quite simply do not know what else to do with them, so they are sent into custody.

It is not my role to question the appropriateness of a prisoner's placement in custody, and, in the case of Sean Lynch, he had been before a criminal court. The criminal court had the evidence from a psychiatrist or a forensic medical officer — a police doctor — who had seen him. They saw his conduct in court, and the court still saw fit to commit him and remand him in custody. Once he was remanded in custody, the Prison Service, along with the South Eastern Trust, had to manage and look after him. The jurisdiction of my office starts and ends at the prison gate. I think that, for Committee members, there are important issues to consider about the appropriateness of this man's placement. Nonetheless, what I have to look at is his time in custody.

It is a lengthy report, but I hope that you have a chance to read it and feel that it provides a balanced and thorough picture of what happened in this unfortunate case. I will not reiterate all the points of the case that the report highlights, but I would like to try to draw out some particular points that I do not think got as much attention as others.

The main conclusion that the report draws is not that there was a single failing but that there was a cumulative succession of failures that led up to the final incident in which Mr Lynch blinded himself on 5 June 2014. In particular, had he received better psychiatric care, this incident might have been avoided. Had there been competent leadership on the grounds, in the prison, on that particular night, this incident might not have happened. I feel, in particular, I have to say, for the two young inexperienced staff who first had to deal with this. Quite simply, on that night, when he first raised the alarm, they were not sure what to do. They summoned help, which came some time later, but they were at the sharp end of a series of failings over the previous eight weeks or so. Culpability must not fall to those two individual prison staff alone. It is also important to realise that Mr Lynch had, quite properly, been taken to outside hospitals on two previous occasions, but in both instances, at two different hospitals in the community, because he was a prisoner, the hospitals had failed to fulfil their duty of care towards him.

'The Safety of Prisoners held by the Northern Ireland Prison Service', is the report published in October 2014 — two years ago — of an inspection conducted by Criminal Justice Inspection (CJI). It made three strategic recommendations, which, it said, should be urgently prioritised. One was for the Prison Service and the trust jointly to review the suicide and self-harm policy. As far as I am aware, that is still outstanding. There were other recommendations to deal with substance misuse. My office looks at specific cases, and Criminal Justice Inspection looks at themes. If, between us, we cannot get recommendations accepted and implemented that would help, it questions the benefits of oversight.

I want to mention particular issues that are, I think, particularly important to draw out for both the trust and the Prison Service. They have not been highlighted so far. I am sure that you are all well aware now of the delayed entry into Mr Lynch's cell on 5 June 2014. What concerns me more is the fact that, when six officers plus a nurse went into the cell, they very quickly turned and backed out, leaving Mr Lynch on his own. By that stage, an ambulance had been summoned, but he was left alone with the possibility of continuing to self-harm. In my opinion, that is less understandable than failing to go in the first place.

The Prison Service has not yet developed an understanding of what a proper handover is. A handover, in my book, is when staff are going off duty — daytime staff in this case — explain to the staff coming on duty at night-time which particular prisoners have issues that need to be addressed. That is not properly understood or implemented in the Northern Ireland Prison Service, and it did not happen in Mr Lynch's case. I come back to the two young officers who were in the first line of response: they did not know what they were dealing with and, because of that poor internal communication, were very poorly equipped to deal with it. They were meant to be supported by Mr Lynch being in his cell with camera coverage, and that was being observed from the emergency control room. The staff in the emergency control room did their observations, but they did not communicate with the staff on the ground, so it was a total waste of time. Again, that begs questions about the procedures and the systems in place that are meant to help vulnerable people such as Mr Lynch.

The Prison Service conducted its own investigation into the matter shortly after it happened, and, in my opinion, that was a poor investigation. Our investigation unearthed failings. I recognise that we had more time and the benefit of hindsight, but, as I understand it, the internal Prison Service

investigation reviewed the same CCTV footage as we obtained, but it did not identify the failings that we were able to identify, nor did it address those failings.

Finally, in simple decency terms, when Mr Lynch was being supported to the ambulance, nobody helped him even to get dressed for the ambulance or provided a wheelchair for him. That is a very simple failing: in anybody's book, at a human level, that should have been done to help the man to get from his cell to the ambulance.

The main issue with the South Eastern Trust is that the forensic medical officer's opinion, which, exceptionally, was provided in writing to the court and sent on to the prison and the healthcare authorities, said that Mr Lynch should be urgently seen and reviewed by a psychiatrist, but it was ignored, and he was not seen. When he was finally seen a couple of weeks later, the diagnosis was correct: he was in a psychotic state and needed anti-psychotic medication. My clinical reviewer, whom we retained to look at this case, said that someone with an acute illness such as that should have been seen as an immediate priority once he entered prison, and he should have been commenced on medication straight away. That did not happen, and that is a fundamental failing in a case like this. Then, when he started to deteriorate and his mental health became worse and worse, no single person took care of the patient to help to manage him. Events moved more quickly than the official responses were able to, and nobody was able to keep up with him or to get a grip on matters to ensure that something effective was done to contain the downward spiral.

Various reviews were conducted: interagency reviews between the Prison Service and the trust; and internal healthcare reviews by the trust. However, those were pretty meaningless as well. Most seemed simply to set a date for another review. There were no outcomes and no plans for how, in future, somebody might get a grip on such cases, manage a man's serious mental illness and care for him properly. When Mr Lynch's prescription for anti-psychotics was increased, it took eight days for it to be administered. I am not a clinician, but the clinical reviewer said that an eight-day delay in dispensing the increased prescription was far, far too long.

I have a couple of concluding comments about things that I think are particularly important. One is that somebody must take care of these patients. I will say it again: there are other patients — patients in the trust and prisoners at Maghaberry — who could have the same sorts of issues as Mr Lynch. Somebody needs to take care of those people and make sure that their care is managed.

My final point, Chair, is that there is a common misunderstanding among the wider public that there is a prison hospital at Maghaberry. There is not, and there has not been one there for some years. That is a point of debate between the trust and the Prison Service. From my office's point of view, various healthcare staff, including the psychiatrist and my clinical reviewer, who is totally independent of the Northern Ireland healthcare situation, said that Mr Lynch could have been better cared for had he been in a clinically observed location within the prison. I do not mind whether it is called a hospital, an inpatient facility or a clinical space, but the Prison Service would certainly welcome some sort of facility to care for people who are as damaged and emotionally disturbed as Mr Lynch.

It is important that you, as elected representatives, help the public to understand that, when courts remand people or sentence them to custody, there is no such thing as a prison hospital in Northern Ireland any more. People who need treatment, whether it is for a sore toe or a serious psychotic illness such as this, have to go to an outside hospital, with all of the problems, such as assessments and transfers, that that entails.

Chair, that is as much as I propose to say for now, and I am open to questions and comments.

The Chairperson (Mr Frew): Tom, thank you very much. As always, you were very clear and concise.

Reading your report — it was very harrowing — I am in no doubt that this is a very serious case. What I get from the report is the overriding belief that Sean Lynch should not have been where he was. That comes out very clearly, even from reading between the lines. That is the first thing, and it is the catalyst for everything that happens thereafter.

I also note that, whilst it is easy to put things in chronological order on paper, there seem to have been many times when a warning light or siren should have gone off in the system, or even in somebody's head, to say, "We need to stop what we are doing and do something different" or, more importantly, "do something more quickly".

I read in your report:

"He was meant to have six mental health reviews pending the psychiatric assessment, but only one took place. It took two weeks for Mr Lynch to see a psychiatrist."

The report also states:

"He was reviewed by the psychiatrist three weeks later and his medication was increased. The clinical reviewer said that, given Mr Lynch's lack of response, he would have expected the dose to have been increased more quickly; and problems may have been compounded by the fact that there was then an eight day delay in administering the increased dosage."

On responsibility:

"Numerous people from the NIPS and the SEHSCT were involved, but nobody took overall responsibility for managing him, either as a patient or as a vulnerable prisoner. Events moved faster than the official reaction".

On the location:

"His final location, Quoile House, was unsuitable for managing someone who was so disturbed."

I could go on for three or four pages in the same spirit. One of the most damning parts is that events moved more quickly than the official response, and it seems to be the case that when it is everybody's responsibility, it is nobody's responsibility. Who has ultimate responsibility for an unwell prisoner?

Mr McGonigle: For their healthcare, Chair, it is quite clearly the trust. The trust is responsible for providing healthcare to prisoners throughout Northern Ireland. The difficulty is that you cannot neatly separate healthcare and, say, security. Prisoners live in a very different community and environment from anybody else in the general population in Northern Ireland. The two need to work together, and you have two very different cultures at work: the Prison Service has to, and does, treat them as prisoners, the trust treats them as patients. Both are correct designations, but it is almost as though one is abdicating responsibility to the other. Primarily, this man was psychiatrically ill. There is a debate, as you and I have identified, about whether he should have been in prison. The fact is that he was in prison, and that is why it is important that the courts understand that there is no prison hospital facility. This man had serious psychiatric ailments that required psychiatric — healthcare — interventions, and he did not receive those sufficiently quickly or with a sufficient degree of seriousness to remedy things.

The Chairperson (Mr Frew): For members' information, I am reading from page six of Tom's report:

"The escalation in Mr Lynch's self-destructive behaviour required treatment at outside hospitals on two occasions."

My thinking is that an outside hospital was, of course, the best place for him to be.

Mr McGonigle: You are right.

The Chairperson (Mr Frew): He was there on two occasions, and:

"His conduct was so challenging that he had to be restrained in one instance and tranquilised in the other, and he seriously assaulted a prison officer in Maghaberry on 3rd June."

On what grounds was he moved back to prison on both occasions?

Mr McGonigle: That is a good question, Chair. I think that the problem with both of the attempted interventions was that he was taken to an outside hospital because of concerns about his physical health after, on both occasions, he had cut and injured himself. If somebody is brought to an outside hospital because they have cut themselves in a certain way or with other presenting symptoms that indicate psychiatric ill health, the protocols require that they should be seen at the outside hospital's psychiatric facility.

The reason why I did not answer your question directly is that Mr Lynch was sent back into prison because the physical issues — the injuries that he had inflicted — were patched up, and, without seeing a psychiatrist or mental health team at either of the two outside hospitals, he was sent back to prison in the expectation that prison mental health people would deal with him. He was let down by two outside hospitals as well.

The Chairperson (Mr Frew): He was in hospital just because of the physical injuries sustained by his own hand. I am not a medical expert — how could I be? — and neither is anyone in the room, but when self-harm is involved, surely a psychiatrist needs to be involved at some point to say, "This man is ill. It is not just about the injuries that you can see and treat", and questions should have arisen then.

Mr McGonigle: Chair, you are completely correct, and the report is completely correct in saying that, too. That is the protocol that is meant to apply to any of us who might end up with similar injuries at an outside hospital, if they were self-inflicted. That person is meant to be seen by someone from the mental health team to assess what has happened; what the background is; what can and should be done about it; and how promptly should that be done. However, because Mr Lynch was a prisoner, at two different hospitals in two different trust areas, none of those things were done, and he was sent straight back to prison.

The Chairperson (Mr Frew): I would be interested to know what would be the case if a person who was not a prisoner was in hospital for the same thing. On a constituency basis, we deal with health issues all the time. Sometimes we think that there are weaknesses in why someone got out of hospital at a given time, and we see such weaknesses daily. It would be interesting to pursue that line.

We all know about the 67 minutes, as your report highlights, and the prison officers directly observing for at least 27% of that time. I also know, from speaking to prison officers, that when prisoners are intoxicated or high on drugs, they sometimes get superhuman strength, and it will take six or seven people to restrain them, hold them down, contain them and prevent them from hurting themselves or anyone else.

You said that prison officers got help and entered the cell, but they then left. Explain that to me again, please.

Mr McGonigle: May I address one further point about the hospital treatment before I come back to that, Chair, if you do not mind? The basic principle that should apply in care in an outside or inside hospital is that any prisoner should have treatment equivalent to that which he would receive in the community, if he had come from the community. That did not apply in this case.

The prison officials who are giving evidence after me will tell you better than I can, but my understanding is that officers are trained in three-person restraint: three officers should be able to restrain a prisoner, in normal circumstances. When the senior officer came on the scene that night, there was a senior officer plus three, which was four. Fortuitously, two further officers, who were not expected, arrived. It is still unclear to me what would have happened or how quickly anything might have happened had those two officers not perchance arrived. It took six of them to go in.

The night before, Mr Lynch had to have his cell open because of a medical emergency. On that occasion, two members of staff sat either side of him and locked his arms so that he could not self-harm, and he did not react.

Mr Lynch was a very difficult person to manage. He was inconsistent and could be volatile and violent. However, I come back to the handover. If a good handover on the night of 5 June had taken place, and the first two officers who dealt with him had been made aware that he had responded positively 24 hours earlier to having his arms locked by other staff, with that confidence and knowledge, they might have been able to talk him down rather than having to wait for six people to go in. In fact, when the six went in, he sat calmly while the nurse spoke to him. The officers stood behind the nurse and let a tiny nurse speak to him. Then, they promptly left again. I just do not understand that. It is nearly worse, to me, to have gone in and left than not to have gone in at all.

The Chairperson (Mr Frew): I just want to be clear: were the injuries already sustained by Mr Lynch at this time?

Mr McGonigle: Yes, they were, but CCTV shows that the staff were then out of the cell for roughly half an hour after that, pending the ambulance's arrival. He was at least in a position to inflict more injuries, and it appears that he may have exacerbated some of his existing injuries. That is the bit that is so difficult to comprehend.

The Chairperson (Mr Frew): I am trying to find a salient piece that I read in the report about the priest.

Mr McGonigle: It is a short two-line quote that Mr Lynch was too difficult for the prison officers to manage.

The Chairperson (Mr Frew): Yes. I am amazed that there is not a failsafe mechanism, policy or process whereby, at some point, a button is hit to signal, "We can't cope with this prisoner".

Mr McGonigle: The process is the transfer direction order, which is the removal from prison to a secure psychiatric setting. In Northern Ireland's case, that is Shannon clinic at Knockbracken Healthcare Park, or Purdysburn, as you might know it. That is a slow process. Beds are scarce and hard to get. People go in both directions. I know of one person who came back from Knockbracken to Maghaberry just a few weeks ago having been moved from Maghaberry to there, which was the right thing for the person at the time. The prison is now very concerned because that person is back, apparently without a diagnosis of any kind. There is a facility, but the process is slow. It takes considerable effort on the part of healthcare and prison staff to effect moves to a secure psychiatric setting.

Mrs Cameron: Thank you very much for coming today. I know that you will not take offence when I say that the report is utterly repulsive, and reading it is making me feel physically sick. I am attempting to read bits of it now. Your job is not an easy one.

Mr McGonigle: I take no pleasure in writing about it, but it has to be spelled out.

Mrs Cameron: It does, and thank you for doing that. It raises more questions than answers. Recently, there have been a lot of questions — I have asked such questions — about the mental health of prisoners and prison officers. It convinces me that some prisoners should not be in these facilities, because they are simply not fit for purpose. Also, I think that prison officers are being left with the impossible task of trying to care for individuals who cannot be cared for in that environment. This is not so much a question as a statement of frustration: what is the answer to this? I am really horrified by your comments about the outside care from two separate hospitals. I think that that is horrific, and the only conclusion is that they probably wanted rid of this character. Maybe they were intimidated or felt threatened by his presence, and it was just a quick fix to get him out of their hair and back to prison. It is completely distressing.

Mr McGonigle: It is indeed. There is no doubt about that. Part of why we got to this situation is not unique to Northern Ireland. The UK adopted a policy of care in the community over 30 years ago, and the rationale for care in the community was that there had been a lot of media coverage of a series of damning scandals about psychiatric institutions. We emptied the psychiatric institutions, and some of those people have ended up in prison. Whether Mr Lynch might have been amenable to psychiatric care in the community is another debate, but he ended up in the criminal justice system, not for the first time. The background to how he got involved in the criminal justice system is spelled out. He ended up as a very unfortunate victim on this occasion, and the prison system and healthcare system in this jurisdiction were not able to cope with him.

Mrs Cameron: You mentioned the emergency control room and talked about officers observing Mr Lynch. For clarification, did you say that they did not communicate with the rest of the prison?

Mr McGonigle: He was on 15-minute observations, which means that he should have been watched every 15 minutes to try to make sure that he was OK.

Mrs Cameron: Physically.

Mr McGonigle: Yes. There was a camera in his room. He was in a special cell for that purpose, and the emergency control room staff watched him, but they did not report findings of any benefit. They might have spoken to the staff on the landing, but that was just to say that he was still self-harming or

was starting to self-harm. Nothing happened because of it. I think that staff at that front-line point of contact really did not know what to do. It is very important to try to understand that, from the prison staff's point of view, the policy is clear: if a prisoner is hanging, bleeding profusely or in a collapsed state, they must intervene. I have seen them go in very quickly in those circumstances. Mr Lynch did not meet any of those three criteria, so they were not sure what was going on. We have no audio facility to tell us what he was saying to them. It is a waste of time having him observed by cameras when nobody took ownership of the case on the night for far too long. Nobody had taken ownership of the case, whether you call him a patient or a prisoner, for six or eight weeks before that to try to head this off, as you suggested.

Mrs Cameron: You mentioned inexperienced staff who were poorly equipped to deal with it. For you, does it raise questions about the suitability of staff? I know that staffing is a huge issue. It is such a difficult working environment, and the Prison Service struggles to keep staff. Does it raise questions about the process of recruitment and whether the service is getting the right people for the job, given that it is so specialised and unique?

Mr McGonigle: It is a very challenging role. The reality of the night staff role is that they do not have a great deal of engagement with prisoners routinely; certainly nothing as extreme as this. For relatively young staff to be faced with a situation like this, probably in the first couple of years of their career, was something they had never contemplated. That is not a comment on the quality of the staff.

The Prison Service has a staff recruitment exercise, and it has a difficult task in getting staff to work in that environment, especially after episodes like this because it causes problems for the recruitment and retention of staff. I am not sure what else it could do in terms of recruitment or retention. Prison officer work is about working with humans in their most extreme conditions. There are about 900 men in Maghaberry and 50, 60 or 70 women, some of whom are equally disturbed, in Ash House. A very special skill set is required for any staff to engage with them — prison officers, healthcare staff and the various ancillary staff who try to support them.

Mr Douglas: Thanks very much for your presentation, Tom. In your initial remarks, you mentioned that you knew a few prisoners who have mental health problems. Research on ex-prisoners shows that, when they come out, mental health is one of their biggest problems. Obviously, they are bringing those mental health issues from the prison. Do we have enough mental health professionals in Maghaberry? How many is enough, I suppose?

Mr McGonigle: That is exactly what they will say: there are never enough. We have more death in custody publications pending, and I am currently looking at some of those at draft stage before they go out for consultation. They are not as sensational as this one, or Mr Kelly's, which was published last week, but a routine concern for healthcare staff in primary and mental health care is that they do not have time to review prisoners' records before they see them. They rely on what the prisoners tell them, which is never good enough. Unfortunately, you cannot take somebody at face value in these circumstances. If a prisoner does not make the list for the GP appointments, they have to wait another week, and sometimes that is too long for all sorts of physical and mental health care reasons. The trust and the Prison Service have to do this within a significantly diminished budget, so there are no easy answers, but if we are going to do it to best effect, the two organisations have to collaborate closely and carefully and to share information thoroughly.

There are not enough mental health care staff, but that is not unique to that particular discipline.

Mr Douglas: Most of them will have seen or heard Mr Lynch and his family and been traumatised, as will the prison officers who have been involved in this. Mistakes have been made, and they themselves have been traumatised. I suppose that my biggest question is this: in relation to any measures that have been implemented since this happened — have any measures been implemented? — could this happen again today or tomorrow?

Mr McGonigle: My office is not in a position to go back and check recommendations. Only when there is a subsequent serious incident like this that we are asked to investigate, or a subsequent death in custody, will we review previous recommendations that were accepted. We will comment on whether or not those were actually implemented as the trust or the Prison Service indicated. At this stage, I do not know whether they have been implemented. Certainly, one of the significant comments for me from the trust was that it views this as a landmark case, and I take that in good faith. I hope that it will end up as a landmark case and that it will help to improve mental health care for people in prison.

Mr Douglas: Thank you very much.

Mr Kearney: Thanks for your presentation, Tom. I thank you for the report. It is very methodical, very systematic and very damning. My perspective is that all prisoners and all members of staff need to be treated with respect, dignity and the highest standards of care. That must be universally applicable to members of staff and every prisoner.

In my opinion, what has happened to Sean Lynch, and by extension to his family, is an absolute travesty. It is incredible that there appears to have been no regard for the core principles, which have to be at the foundation of every aspect of life but particularly in our penal system, of respect, dignity, duty of care and sensibility for humanity.

I would like to ask you a couple of questions that spring directly from your report. First, can you enlarge on the reference to the internal investigation that was carried out by the Prison Service itself and your observation of poor quality?

Mr McGonigle: Quite simply, it appears to me that that internal investigation was done, as the Prison Service will do, fairly quickly after the event. I am told that part of that investigation included a review of the CCTV footage; the same CCTV footage that we got probably about a year afterwards. I cannot understand how anybody, whether within the Prison Service or outside it, could look at that and not see the failings — they are so glaring — or the need to take prompt remedial action. That is it in a nutshell. I do not know who comprised the team or what levels of people within the Prison Service actually reviewed it, but it would have to have been people of some level of seniority.

Mr Kearney: From within Maghaberry itself.

Mr McGonigle: Well, I do not know whether it was Maghaberry itself or headquarters, but, as far as I am concerned, it is a corporate responsibility for the Prison Service.

Mr Kearney: Does it fall within your remit to have enquired into the remit of that particular investigation and who would have been tasked —

Mr McGonigle: It certainly could.

Mr Kearney: — with its execution?

Mr McGonigle: Yes.

Mr Kearney: It does fall within it.

Mr McGonigle: Yes.

Mr Kearney: Why are you not in a position to provide us with more information on the terms of reference, the execution of the terms of reference, and those staff who were responsible for overseeing the quality of the review?

Mr McGonigle: It is not that I am not in a position to do it, but I do not have it with me here. I have copious documentation. Behind this report lie probably five or six large ring binder folders of information.

Mr Kearney: Are you satisfied with the remit that was set for that investigation and that it was carried out in a thorough fashion?

Mr McGonigle: On the remit, I cannot recall what their terms of reference were, so I would not pass comment on those until I look at them again. As I have said in the report, and I have said it again today, I am certainly not satisfied that it was thorough or anything approaching thorough.

Mr Kearney: That ties to my next question. Would it have included interviewing the members of staff who were involved on the night when Sean blinded himself and on the previous night, when he was physically restrained by prison officers?

Mr McGonigle: From memory, it certainly included interviews with the staff who were involved that night, 5 June. I am not sure about the night before.

Mr Kearney: OK. Now, obviously, the night before, a senior officer or someone in authority gave an instruction to intervene and physically restrain Sean Lynch to ensure that his hands were kept away from his body. A similar instruction was not given on the night when the most severe self-mutilation and blinding took place. Can you explain to us what, for me, is a stark contradiction in that, in the space of 24 hours, one level of authority, the night before, directed that there should be an intervention, which was successful, but there was a failure to provide similar direction when it actually appears that there were more staff available outside the room to do the same? Are you in a position to clarify or explain that?

Mr McGonigle: Yes. Basically, it is down to individual decision-making and judgement by the person who is in control at that point in time. You had two different people on two different nights making two different judgement calls about how they should restrain effectively. I think that I have said in the report that, when we interviewed one of the staff who was involved on 5 June, who was accompanied by a representative from their trade union, they suggested that he should have been handcuffed. Now, to handcuff somebody to save themselves from self-harm is pretty undignified, but I would think nonetheless that it was better than allowing them to continue to self-harm. To grip them by their two arms would have been better again. That may just have been a local initiative by the person who was in control on the previous night. It is two different individuals making two different judgement calls as they saw fit at the time. I think that the judgement calls on 5 June were very tardy and inappropriate when they were actually executed.

Mr Kearney: You make reference to the idea of a handover policy. That is fraught because there appears to be no understanding of the process or effective communications. Is there a consistent and codified handover policy?

Mr McGonigle: Again, Prison Service officials will be able to tell you whether or not the handover policy is codified. My understanding is that there is an expectation of a handover between each shift, whether coming off in the morning or coming off in the evening and handing over to the staff coming on duty. I know from other institutions, in particular, juvenile institutions, that that is done both in writing and verbally. The difference, I think, is that juvenile institutions carry much smaller populations. I think that there are only a small number of people whose circumstances are as extreme as Mr Lynch's. There should have been a handover, and that handover should have explained how his previous eight or 12 hours were, or whatever length of shift those staff were on duty for, and what needed to be done to keep him safe through the night. So, it is codified to the extent that there will be a reference to it in, I guess, governor's orders, but the culture, in my experience and from what I have seen in the Prison Service over many years, does not extend to what I have seen in smaller juvenile institutions, where it is done in a way that I regard as being in any way effective.

Mr Kearney: Are you saying that there is a satisfactory approach in juvenile institutions?

Mr McGonigle: Yes. Juvenile institutions; for example, children's homes.

Mr Kearney: That is very helpful. You referenced the cultural issue. I want to ask you, in your view, based upon your assessment of the case, to what extent did what happened to Sean Lynch arise as a result of cultural or attitudinal approaches towards that particular prisoner and perhaps the prison population in general? If that is the case, is that systemic within the prison system itself?

Mr McGonigle: I do not believe that anybody on duty, either on the night of 5 June or on the previous nights when he self-harmed, set out to permit him to do that level of self-harm. What I think happened was that they simply did not know what to do. You have varying degrees of understanding of that approach. For me, it is least understandable with the person in charge who was experienced and senior to the others and therefore should have recognised the need to intervene promptly when things were as serious as they were. While that was not, I do not believe, an attempt to permit him to do serious self-harm or any prisoner to self-harm — I do not think that anybody sets out with that intention — the inertia, the lack of proactivity and this attitude of, "I'm not sure what we should have done" —

Mr Kearney: Which can lead to indifference.

Mr McGonigle: It certainly comes across as indifference. Whether it is intended as indifference, I am not sure; I do not think that it is actually, but, certainly, that is part of the problem. It gives an impression almost of brutality, never mind indifference. I do not believe that brutality or indifference were intended, but that becomes the public perception of it.

Mr Kearney: I have just two more quick questions, if you do not mind, Paul. You cite an anomaly, a contradiction, between governor's orders and the NIPS suicide and self-harm policy. For me, that is a stark contradiction that certainly creates context for misunderstanding. It also creates context for indifference and, indeed, systemic indifference in those very exceptional circumstances, which I accept are entirely challenging. Why does that anomaly exist, and who is responsible now for fixing it? Whilst such an anomaly exists, I fear for other prisoners who also live with that type of mental illness or are challenged with very serious mental conditions.

Mr McGonigle: Why does the anomaly exist? I think that it is because — again, Prison Service officials will tell you better than me — governor's orders grow each month as new orders are added or are amended, whereas policies are more fixed in time. You will recall that I said there was an inspection two years ago that suggested there was an urgent need to review the suicide and self-harm policy, and the South Eastern Trust signed up to the NIPS suicide and self-harm policy. That was meant to be a joint approach to reviewing that policy, but it has not happened. That was, and still is, a chance to remedy the anomaly, but it has not yet been taken. That is probably the most direct answer that I can give to that question.

Mr Kearney: My very last question — it is brief, Paul — is this: are there implications now arising from this case, which you or others have described as "landmark", for the progression of prison reform?

Mr McGonigle: I am always mindful of the fact that we, in my office, come in to look only at cases where there have been significant failings, issues like death in custody or serious self-harm incidents like this. I am not keen to extrapolate too widely. Hopefully, when we look in such depth, as we did in this case, there will be significant learning from it. It does not mean that everything is broken or wrong, but it means that significant lessons need to be learned. I would always encourage you to read, in conjunction with our reports, the Criminal Justice Inspection reports because they look at the totality of how the prison system runs. They look at themes such as vulnerable prisoners. Again, I have quoted a vulnerable prisoner inspection of two years ago where a very important recommendation has not been delivered by the two key parties involved.

I would not take from it that this means that prisoner reform is impeded or need be impeded. I would actually see this an opportunity for prison reform to improve and progress. This was just over two years ago. Things change all the time. This should help prison reform, I hope, by taking a detailed look at one particular case.

Mr Lunn: Thanks for your presentation, Tom. I am involved with another case, involving not a prisoner but a prison officer who had to retire because of an incident that happened within Maghberry. I have to say that the attitude of the senior authorities of the Prison Service has been nothing short of appalling; obstructive, uncooperative and unhelpful. Something that should have been dealt with in six months is now, I think, into its third year. How would you assess the level of cooperation that you got from the senior authorities in the prison in the preparation of this report?

Mr McGonigle: The way in which my office is currently structured will change because we are to be placed on a statutory footing, which will give us an automatic right to do investigations on matters like this, but, as we talk today, my office has no right to investigate unless we are invited in by the director general. That is what was done in this particular case. That is what is done in each death in custody case.

I have been in this post for just over three years, and the director general and the Prison Service have never been anything other than open, transparent and helpful. They have given us all the information, sometimes to their detriment. Sometimes it is a bit slow coming through, but we get everything we have asked for — CCTV footage, documentary evidence or the access to interview staff that we require. They have always worked OK with my office.

Mr Lunn: At the time when you were preparing this particular report, there was no obstruction —

Mr McGonigle: No. Bear in mind that they did not have to ask us in at all in the first place. They did ask us in. There was no obstruction whatsoever. They gave us the CCTV footage. There was no difficulty at all.

Mr Lunn: In terms of practicality, you said that there was no audio recording on the CCTV footage. Is that satisfactory?

Mr McGonigle: It is not satisfactory in this case because Quoile House, where Mr Lynch was held, is a modern house and the CCTV footage there is meant to be linked to an audio facility. Apparently, in this instance, it was not working. Why that was, I do not know. I asked for and obtained records of the referral to the trades department to establish that that was the case. It was verified that it was not working on that occasion and that it was promptly rectified. We have no audio in relation to this.

Mr Lunn: Was it not working across Quoile House or just in this particular cell?

Mr McGonigle: Across Quoile House; the four new landings in Quoile House.

Mr Lunn: I cannot help thinking that the CCTV — I take it that it is good-quality CCTV.

Mr McGonigle: It is pretty high-resolution, yes.

Mr Lunn: That is one thing on its own, but with audio it takes on a new dimension completely. You would have been able to hear what this poor fella was saying. Is his blindness permanent?

Mr McGonigle: I have met him just once, about a month ago. Yes, I think that it is. It is not for me to say, but I am fairly certain that it is.

Mr Beggs: Thanks for your presentation. I want to go back to the two hospital visits. The physical conditions were treated, but he was returned to prison when there were severe mental health issues, including self-harm. To what extent are A&E clinicians aware of the level of care that exists in prison? Secondly, are prisoners ever transferred to secure mental health accommodation via acute hospitals?

Mr McGonigle: You have put your finger on something that we talked about before, but it is worth reiterating. If a clinician in a busy A&E department is aware that the person they are dealing with is a prisoner, and they are busy with 20 or 30 other cases, the clinician may think, for the sake of expediency or simplicity, of sending them back to prison to be looked after there. I do not know if that was the thought process that clinicians went through in two separate hospitals on two separate occasions with Mr Lynch, but I can see how it might have been. That should not have happened, and it would not happen to any of us, as members of the public, who went into A&E with a self-inflicted injury.

Sorry, what was your second question?

Mr Beggs: Are prisoners ever transferred to secure mental health accommodation?

Mr McGonigle: Yes, is the short answer. I mentioned earlier that I am aware of people who have gone from Maghaberry to Shannon clinic in Knockbracken Healthcare Park and in the other direction. I am told that it is a difficult process to effect those transfers: the people who run Shannon clinic have to be persuaded that a person is so ill that they require hospitalisation in a secure setting. The other option available is Carstairs in Scotland, which is a higher security classification for people who require longer-term or more secure confinement. Some people from Northern Ireland have been sent there — very few — in exceptional cases.

Mr Beggs: Is the availability of such secure accommodation a factor that limits transfers of prisoners?

Mr McGonigle: That is more for healthcare professionals to answer. The reckoning is that the number of beds in Shannon clinic is sufficient for the Northern Ireland population, but that is for people coming from the community; only a small number of people go from prison to Shannon clinic. It brings me back to a point that I raised earlier: while Northern Ireland may have sufficient secure psychiatric beds outside the prison setting, several people who were much closer to this case than I am, and who tried to manage Mr Lynch and his psychiatric problems, said that he would have benefited, and his

care would have benefited, from somewhere in the prison where he could have been cared for in isolation from the general prison population.

Mr Beggs: There is one interesting incidental issue that I would have thought could well be related. In your piece on tuck shop orders, you say that there was a trebling of the normal tobacco order, tobacco essentially being the prison currency. Mention is made of Mr Lynch having debts and a marijuana problem; he may even have been bullied. Is there sharing of information, particularly where vulnerable prisoners are involved, on unusual issues, such as the trebling of a tuck shop order? That could trigger further scrutiny of what is happening.

Mr McGonigle: That is why we raised this. It might seem like a routine, and there is a routine process where prisoners get their tuck shop every week, pretty much. Sometimes when there is a bank holiday, they get two weeks' worth at a time. Coincidentally, we came across that issue in the process of looking at all his transactions while he was in prison, and it raised questions for us.

Mr Beggs: Is that information shared?

Mr McGonigle: Not routinely, no. We fed it back to the Prison Service and made a recommendation, on the basis that, if somebody is trebling a tuck shop order, that might be because they are being bullied or are trading illicitly, although tobacco is itself legal material, and is therefore something of concern. It is about good intelligence sharing to help manage the prison population.

Mr Beggs: If I picked it up rightly, there was no CCTV in Erne House.

Mr McGonigle: That is right.

Mr Beggs: Given the high level of poor mental health in prison, the significant level of drug problems and the issue of bullying, why is there no CCTV?

Mr McGonigle: It is an older part of Maghaberry. It is one of the original buildings that were opened in 1987, I think, just coming on 30 years ago, and it was not fitted with CCTV. There were four houses like Erne House; one has since been retrofitted with CCTV as part of a rolling programme of upgrading in the Prison Service. More modern houses, such as Quoile and some others, had CCTV built in from the outset.

Mr Beggs: I would have thought that it was an essential management tool. Is there a schedule for fitting it?

Mr McGonigle: Again, I suggest that Prison Service officials would be better able to tell you that.

Mr Beattie: Tom, thank you for your report. Your oral evidence has been first class. The 63 recommendations are in depth and make perfect sense. Reading each of them, I thought, "Why is this not the case already?" I echo what Pam said. This is truly disturbing: the incident is disturbing; the lack of compassion is disturbing; the lack of action is disturbing in many ways. I just get the sense that the infrastructure and processes in this prison are not there to be able to deal with this type of incident. I know that Sean Lynch's case was complicated, but his was not the only one; there are many more like his.

Tom, it might be unfair to ask you, but I will ask anyway. I have raised before the issue of minimum manning levels, that is, the supervision of prisoners. When there are as few as 25 prison officers looking after the whole prison in the evenings, I can see why the supporting prisoners at risk (SPAR) processes for handover are not being done properly. Do you think that there is an issue with the resilience of the minimum manning level?

Mr McGonigle: Yes, is the short answer. I go back to local leadership on the ground on the nights that Mr Lynch self-harmed. It is for local leaders to make calls. The Prison Service, like the South Eastern Trust, has to work within a severely depleted budget; therefore, it has less money to spend on staffing. That will be a huge challenge into the future. We still have better staffing levels than prisons across the water or down South. It is probably only going one way, so the challenge will be how to manage people who either have natural conditions, such as a heart attack, or inflict self-harm. To get officers there in sufficient time and in sufficient numbers to safely unlock the prisoner without risk of further harm to other prisoners or staff is the problem. We collectively as a society — you as

politicians — have to look at how to fund this in relation to all the other competing priorities that there are.

Mr Beattie: I feel that prison officers in many ways and the whole system are overwhelmed by instances of mental ill health. It is easy to point the finger and say, "That guy made a mistake on this particular night", but at a strategic level it is being overwhelmed. Do you know whether there is a continuous training regime for prison officers to ensure that they understand and can identify issues of mental health or self-harm indicators?

Mr McGonigle: There is training for sure, some of it good. It is a mixed bag, I suppose like everything else. New staff go through a training programme in the Prison Service college, and that is adequate for the job. None of that prepares a person for being confronted with a situation like this. Coping with something that extreme is much more about strength, resilience and personality. In that case, the best trained person in the world might have intervened very poorly and a poorly trained person very well. It comes down to a person's character, integrity and personal qualities as much as to training. Of course, prison officers need to be trained, but that will not guarantee that every prison officer will intervene successfully in a scenario such as this. In answer to your question: there is a training regime, but more than that is needed. You need to select the right people, and you need to support them through a very challenging job as well.

Mr Beattie: Just a final question to follow on from Declan. There was an incident learning account very quickly after the incident took place, and you said that it was made available to you. Is that available outside your office? Is the learning account available to us, for example?

Mr McGonigle: That is a question for the Prison Service. We were given it. We asked for everything, and we got everything we asked for, including that account. It would be for you to ask the Prison Service whether it is prepared to let you have access to that.

Mr Sheehan: Thanks, Tom. I have just a couple of short questions. Was there ever a prison hospital at Maghaberry?

Mr McGonigle: Yes, there was. Responsibility for prisoners' healthcare transferred between 2008 and 2012 — it took a period to transfer the staff across — but until roughly 2012 or perhaps 2013 there was a hospital.

Mr Sheehan: Who took the decision to close it?

Mr McGonigle: The South Eastern Trust.

Mr Sheehan: You said that, after the internal prison investigation into this incident, it was another year before you saw the CCTV. Why so long?

Mr McGonigle: It was not all the Prison Service's fault. We would have had the CCTV before that, but by the time my investigators got round to looking at it along with the documentary evidence and to interviewing staff, it was a while, and we also needed information from the trust. It was not the fault of anybody in particular, but as soon as I saw it, I raised it with the director general and said, "Look, there is a clear issue here that your own investigation has not identified". By that stage I had done that.

Mr Sheehan: How long after the actual incident were you called in?

Mr McGonigle: We were called in on, I think, 23 June. So what was that — two-and-a-half weeks?

Mr Sheehan: It was a couple of weeks, yet it was another year before you saw —

Mr McGonigle: I am not blaming the Prison Service for that. By the time I personally saw it, my investigators had seen it, but there was a lot of work involved in going through the footage and analysing it. That involved checking out the timings and who was present, and there was more than one camera to be analysed as well. So, it was not that the Prison Service was tardy in handing it over to us.

Mr Sheehan: Are you saying your organisation was tardy in bringing forward the report?

Mr McGonigle: No, I am not — not at all. I am saying that there is a process we have to go through. We do not just look at anything in isolation; we also interview staff and analyse documentation, such as SPAR documents, which were comprehensive in Mr Lynch' s case, as well as wing files and medical records. We need to look at all that in the round before we draw any conclusions.

Mr Sheehan: I suppose this investigation is quite unique, certainly given his injuries, which were self-inflicted anyway, but is there any way an investigation like this could be carried out a lot more quickly?

Mr McGonigle: I would like to think so. I will tell you what will help, and this will help you to understand the process. Whenever we are asked to do something like this, we ask for what we call a critical evidence list. That includes every bit of documentation, including things like tuck shop records, wing records, SPAR documents and CCTV footage. We listen to phone calls, so we transcribe those. It takes quite a while to get all that material. It takes a particularly long time to get it from the South Eastern Trust. It will say its priority is front-line service delivery, which I understand.

We compile that, analyse it and try to get it into some sort of coherent sequence to go into a draft report, which then goes out for a factual accuracy check. In this particular case, that had to run in tandem with the South Eastern Trust's internal investigation, which took considerably longer than it expected. It took a huge amount of time; it took much longer than I would wish for a factual accuracy check to come back from the trust. It took less time to come back from the Prison Service. It then had to go to the family for their view as well. It is the same with death in custody investigations. This is the longest, easily, I have been involved with. But still, death in custody investigations take too long because that process is not a top priority for the Prison Service or the trust, which is more focused on delivering front-line service, and I understand that.

Mr Lunn: Just to follow on and without meaning to be critical, Tom, although perhaps hinting at it, if you have decent resolution, high-quality CCTV, is that not the first thing you would look at rather than gather all the other stuff and then look at it?

Mr McGonigle: Not necessarily, no. The fact that it is high-resolution would not make any difference to how quickly we would look at it.

Mr Lunn: I am just repeating your words. Ideally, it is a bonus if there is good CCTV, but in trying to establish what happened initially, would you not look at that first?

Mr McGonigle: No, not necessarily at all. We might, on some occasions, but it depends on when it comes in and on what my investigators are doing on this and other cases.

The Chairperson (Mr Frew): I have just a couple of follow-up questions before we let you go, Tom. It has been a very crucial and important session we have had with you today on this very serious report. You said in some of the questions and answers you make recommendations but you cannot really chase them up because it is not your place. Surely it could be the place of the Prison Service and the trust to give you a periodic update. What stops them from doing that?

Mr McGonigle: Again, it is for them to answer, but when I have asked that question of them, they say it is bureaucracy and they are busy delivering front-line services. When they accept recommendations, we come back and look at them again to find out whether they have been delivered. That is for us to do, but they are busy. I get that, but that is the response we get.

The Chairperson (Mr Frew): It is the type of idea that says everybody has enough to do. Is that body accepting of your findings of it?

Mr McGonigle: It is, and I welcome that. Again, our findings pretty much mirror its report, and its investigation mirrors what we found. It is not a public report, as I understand it, but again, that is a matter for it to answer. But yes, it has said it is accepting them. It met Mr Lynch and his family, too, to go over it with them.

The Chairperson (Mr Frew): It is a very lengthy report and a very thorough investigation. You have a lot of recommendations — 63 — and some have, of course, been made before, while others have not. You would want them all to be accepted and completed, but are there two or three that you really see standing out?

Mr McGonigle: For me, the one headline in this is that when a prisoner has, such as in this case, mental health that is deteriorating very quickly, somebody needs to grip that situation, take care of that person as a patient and make sure their needs are looked after. If they are moved from one house to another, they should follow them around, make sure there is good communication between health professionals and Prison Service professionals and that they get prompt and effective treatment. There should be nobody expecting someone else to do it or working on the basis of assumptions, which happened in this case.

The Chairperson (Mr Frew): I am going to ask a very unfair question of you, but you will be honest in the context, I am sure. If we had either a hospital wing or a psychiatric hospital to meet the needs of our prison population, as well as our general population, how many beds would we need and how many would be for prisoners?

Mr McGonigle: I do not know. I hear stuff anecdotally, and I do not know the figures at Maghaberry, but I know there are around 900 prisoners. On average, around two or three times each year, I sit in on a weekly meeting with the prisoner safety and support team, just to get a sense of who is on the radar. Routinely, there are 12 or 15 men whose cases are discussed at those meetings. They are not all as extreme as Mr Lynch's circumstances, but some of them are on that spectrum. Plus, some of the women at Hydebank have very significant issues.

The Chairperson (Mr Frew): Thank you very much. I think that is all from the Committee in this session. Tom, thank you very much. It is a very worrying report, and I am glad we were able to talk to you about it.

Mr McGonigle: Thank you.