Annual Report

2019-2020

The
Prisoner
Ombudsman
for Northern Ireland

Contents

	Page No
Foreword	3
Background	6
Mission and Principles	8
Organisational Structure and Responsibilities	9
Management Commentary	11
Complaints	16
Complaint Case Studies	23
Deaths in Custody	27
Corporate Affairs	28

Foreword

It is my pleasure to present my Annual Report for April 2019-March 2020.

This report represents my first full year in office as Prisoner Ombudsman, as I took up office just a month before year end last year. It has been a privilege to get to know the work of the office, work with partners and begin work to modernise office practices. Above all, it has been a privilege to work alongside dedicated and compassionate staff whose professionalism and commitment to their work is unstinting.

The demands on the Prisoner Ombudsman's work are varied and fluctuating. Numbers of complaints rise and fall, issues of concern can change and investigative processes bring new and sometimes unexpected challenges as investigators uncover information.

The number of complaints received from prisoners decreased by almost 20%, from 408 in 2018-19 to 328 for this reporting year. We will continue to monitor the number of complaints being received by the office, keeping in mind the need to ensure it is clear to all who can make a complaint and how to go about bringing their complaint to my attention.

It is of some concern to me that my office did not receive any complaints from visitors to prisons. While concerns may be addressed at an earlier stage and with the support of voluntary organisations, particularly in the visitors' centres on all prison sites, nonetheless it is improbable that there are not matters of concern to visitors, which it would be appropriate to bring to my attention.

It is also of some concern to me that the majority of complaints continue to come from Maghaberry Prison in comparison to the other prisons. 92% (302) of complaints come from those in custody at Maghaberry, of which 54% (163) are from separated prisoners. 6.4% (21) of complaints come from those in custody at Magilligan. 1.2% (4) come from the young men in custody at Hydebank Wood and 0.3% (1) from the women in custody. This situation is likely to have a number of influencing factors which need to be better understood by my office. A number of measures were in place to address this, for example, holding Ombudsman Clinics on site to enable prisoners to bring forward their complaints. However, to date none of the measures taken have been as effective as we would have hoped and in-year we suspended clinics to give us time to consider if they were an appropriate use of our resources. Business planning for 2020-21 will provide an opportunity to consider issues such as this.

As a result of investigations into complaints, 146 recommendations were made to the Prison Service. 81% of those recommendations were accepted at the time of writing.

During the year 7 investigations were completed by the Death in Custody team and four were published. Of the 10 recommendations made in those reports, 90% were accepted.

Two deaths in custody were notified to the office. There was a significant increase in notifications of post-release deaths. My office can investigate post-release deaths, largely up to 14 days after release. The terms for post-release investigations are drawn in relation to what we are tasked to investigate: whether or not the death has anything of concern from the person's time in custody. By and large, when 14 days have passed the connection to the individual's time in custody has diminished, and it becomes the responsibility of new service providers to deliver support where it is required. The increase in notifications of post-release deaths does not necessarily imply an increase in deaths. Notifications can come from a number of sources, including the Prison Service, PSNI, PBNI, hostels, non-statutory organisations and families. While there is no statutory obligation for anyone to advise my office of a post-release death, significant publicity at the beginning of the year has most likely played a part in increased notification. This heightened public interest influenced a decision by the Prison Service, in conjunction with the South Eastern Health and Social Care Trust, to establish a working group to consider post release deaths taking account of key issues identified from the work my office has done over a number of years.

It is my intention to provide a more interactive evidence base on the website which will allow persistent issues to be reported to the public. This work will take some time to put into place. It will require a new approach within the office to harness the vast amount of information held by the office and utilise it as a strong evidence base. This will provide a firm foundation for identifying concerns, issues that persist, how concerns are being addressed and how recommendations are implemented. The purpose of this reporting is to both increase public information and also to increase the impact my office makes on behalf of prisoners. Combined with new ways of working, to embed and strengthen the learning approach, it is my hope that change will not only happen but be monitored and reported on.

Statutory footing remains to be implemented and I am committed to putting the necessary changes in place to deliver what will be required. During the year we worked with our Sponsor Body to inform regulations and identify a work plan. I am grateful for the additional Grade 7 support provided to the office by the Department to quickly scope out issues to be addressed and assist us to focus on implications of statutory footing particularly for process and practice.

Throughout the year staffing has been a recurrent theme. We were without a Director of Operations between October 2019 and March 2020. I am particularly grateful to my Deputy Principals (Senior Investigating Officers) who stepped up and took on additional tasks which put extra pressure on them. Both of them were willing, co-operative and creative and the sense of working as a team was significant. I pay tribute to both of them and indeed to all of the staff who took on extra duties and assisted both Deputy Principals with their additional workload. A number of staff at staff officer level moved on from the office and recruitment, which can be a slower than hoped for process, brought 3 new investigators. During the year we had to decamp from the office while essential maintenance work was carried out. A number of months out of our normal working environment had some impact on workflow but by and large staff coped well but we were glad to return to our own office.

A new Director of Operations, Carmel McLarnon, took up post on 1st March 2020. Carmel and the 3 new investigators had only just begun their induction and learning when the spectre of Covid-19 became a reality and we moved into lockdown towards the end of March. This was to have a significant impact on work delivery in 2020-21 which could not have been foreseen.

We ended the year wondering what was ahead of us with Covid-19, facing the 'working from home' challenge, with more complaints still to be investigated than we would have liked, with some Death in Custody investigations not completed as we had hoped and with staff still to be appointed. I am grateful that we also ended the year with staff continuing to be enthusiastic about their work and concerned to do their best for those who have investigations with the office. Their vision and commitment is second to none and I thank them for their work and look forward to working with them in the year ahead to increase our influence and impact for those who continue to rely on our provision of an independent and impartial investigation service.

LESLEY CARROLL
Prisoner Ombudsman for Northern Ireland
January 2021

Background

The Prisoner Ombudsman's Office was set up in 2005 following the Steele review which was commissioned because of concerns about staff and prisoner safety in Maghaberry Prison. Amongst other things, the review suggested that the establishment of such an office would *"make a valuable contribution to defusing the tensions which are bound to arise in prisons in Northern Ireland."*

This contribution is fulfilled through two specific functions:

- Investigate and report on Complaints from prisoners and their visitors; and
- Investigate and report on Deaths in Custody (DiC).

The Prisoner Ombudsman's powers regarding investigation of complaints by prisoners or visitors to prison establishments are currently set out in Rule 79 of the Prison & Young Offender Centre (NI) Rules 2009.

The Prisoner Ombudsman has a standing commission from the Director General of the Prison Service to investigate deaths in prison. She does not have any statutory powers in this matter. In addition, the Ombudsman investigates post-release deaths (occurring within 14 days of release from prison) and serious adverse incidents within prisons.

All our investigations are guided by "The Principles of Good Complaints Handling" which are Clarity of Purpose, Accessibility, Flexibility, Openness and Transparency, Proportionality, Efficiency, and Quality Outcomes. Terms of Reference govern the investigations. They can be found on the website **www.niprisonerombudsman.gov.uk** Detailed manuals have been developed to guide staff in their investigations and these are regularly updated.

We believe the most productive way to promote improvement is by working in collaboration with the Prison Service and SEHSCT, on the basis that we all share the common aim of improvement. Draft Death in Custody reports are shared with the Prison Service, SEHSCT and the next of kin; and final reports are also sent to the Minister of Justice and the Coroner's Office, so that the facts plus our analysis and recommendations are shared with those who are directly affected. Our preference is to publish Death in Custody reports in full in order to serve the public interest. However we must balance publication against legal obligations in respect of data protection and privacy, and we take careful account of next of kin views when considering publication. We therefore offer to anonymise reports and redact dates or other identifying information when a report is to be published.

Draft complaint reports are shared with complainants and the Prison Service to ensure factual accuracy; and we ask the Prison Service to share draft reports with any identifiable staff who are subject to criticism. Complaint reports are not published in order to protect the privacy of individuals involved. However, summaries are included in the annual report and in "Inside Issues" which is our bi-annual publication for prisoners to keep them informed about the work of the office and increase their knowledge of the complaints process and its value to them. Inside Issues is also available on the website.

Mission and Principles

The Prisoner Ombudsman's work is underpinned by a mission statement and six supporting principles.

MISSION STATEMENT

To help ensure that prisons are safe, purposeful places through the provision of independent, impartial and professional investigation of Complaints and Deaths in Custody.

Principle 1
INDEPENDENCE

To maintain and strengthen confidence in the independent and impartial approach of the Office of the Prisoner Ombudsman.

Principle 2
PROFESSIONALISM

To continuously review and develop investigation processes for Complaints and Deaths in Custody, ensuring high standards of investigative practice, robustness, a proportionate approach and balanced reporting.

Principle 3
SERVICE-ORIENTATION

To provide an effective and courteous service to all stakeholders and positively influence the implementation of recommendations in order to assist the Prison Service and SEHSCT to deliver a purposeful, rehabilitative and healthy regime.

Principle 4
CLEAR COMMUNICATION

To maximise awareness of the role of the Prisoner Ombudsman among key stakeholders, and to keep those to whom we provide a service fully informed about the content and progress of investigations in which they have an interest.

Principle 5
EFFICIENCY

To ensure the office uses its resources efficiently and complies with relevant legislative and governance requirements.

Principle 6
FORWARD LOOKING

To develop the role of the office to meet emerging needs.

Organisational Structure and Responsibilities

The first Prisoner Ombudsman for Northern Ireland was appointed in 2005.

The Prisoner Ombudsman is the head of the organisation and as such, has responsibility for ensuring the office conducts investigations and reports within its remit. A Director of Operations supports the Ombudsman's work and has particular responsibility for corporate governance, process assurance, staff support and delivery of the Ombudsman's strategic objectives. The Director of Operations is also the Budget Manager and has responsibility for day to day running of the organisation.

The Ombudsman and Director of Operations are assisted in their managerial roles by two Senior Investigators. The management team receives monthly reports including updates on current investigations, budget expenditure and staffing.

Corporate Governance

The Prisoner Ombudsman is an "Independent Statutory Office Holder," currently appointed by the Minister of Justice under section 2(2) of the Prison Act (Northern Ireland) 1953, as extended by section 2 of the Treatment of Offenders Act (Northern Ireland) 1968.

The Prisoner Ombudsman is accountable to the Northern Ireland Assembly through the Minister of Justice, and acts independently of the Prison Service. She meets regularly with the South Eastern Health and Social Care Trust in respect of death in custody investigations.

Corporate governance is delivered through biannual formal meetings with the Strategic Policing Policy and Sponsorship Branch, at which key corporate documents and processes are reviewed. Financial probity is overseen by the DoJ Internal Audit Unit. An Annual Report is prepared after the end of each financial year and published on the Ombudsman's website. The Director of Operations is responsible for ensuring that the Prisoner Ombudsman's policies and actions comply with DoJ rules and processes and for managing the resources allocated to the office efficiently, effectively and economically.

Staffing

On 31st March 2020 the staff complement comprised the following:

- Prisoner Ombudsman;
- Director of Operations;
- 2 x Senior Investigators;
- 6 x Investigators; and
- 4 x Administrative Support staff.

The Prisoner Ombudsman is a public appointee and all other staff are Northern Ireland Civil Service Employees.

The Prisoner Ombudsman's Office aims to conduct itself according to best current principles, and to serve as an example of good management practice. The terms and conditions of staff members are those of the NICS and the culture of the organisation is modelled on a modern, knowledge-based business. The health and wellbeing of staff is of paramount concern.

Staff are expected to work beyond conditioned hours when the need arises. That is matched by an on-call allowance, time off in lieu and flexibility in working practices, particularly to meet the needs of those with caring responsibilities.

Staff are also expected to comply with the standards and principles laid down in the Civil Service Management Code, the NICS Standards and Conduct guidance and the NICS Code of Ethics. These set out in detail the rules governing confidentiality, data protection, acceptance of outside appointments and involvement in political activities.

Towards the end of the year, additional operational challenges were encountered with the COVID-19 pandemic and my office was significantly impacted as we moved into the 2020-21 reporting year.

Finance

The 2019-2020 opening budget was £648,000 of which the salary budget was £585,000 (90.3%).

Strategic and Business Planning

A Strategic Plan was due to be produced by October 2019 to set out the vision for the office and the work that flows from that vision and this was due to coincide with a revised Business Plan. Unfortunately, operational priorities and resourcing issues have hampered progress on both the Strategic and Business Plan and further work on both of these critical exercises was delayed until the 2020-21 year.

Management Commentary

Statistical Headlines for 2019-2020:

- Investigations initiated into the deaths of 2 prisoners and 11 ex-prisoners.
- 7 investigations completed by the DiC team and 4 reports published.
- 10 recommendations for improvement made in DiC and post-release reports of which only 1 was not accepted.
- 328 individual complaints received, decrease of 20% from 2018-2019.
- 92% of prisoners' complaints came from Maghaberry (54% from separated prisoners).
- 31% of complaints were Upheld or Partially Upheld.
- 146 recommendations for improvement were made in complaints reports of which 81% were accepted at time of writing.

Performance against targets 2019-2020

We met most key operational objectives such as conducting all Complaint and DiC investigations within our remit, and sharing the findings with prisoners, their families and relevant agencies. However delivery within timescales remained a challenge.

1. Statutory Footing

Subject to legislation being in place, identify issues to be addressed in the underpinning Regulations; and update Terms of Reference for investigating deaths in custody and complaints.
Work continued with Sponsor Body to inform regulations and a plan of work was agreed to identify issues and lay the foundations for Statutory Footing. An additional Grade 7 resource was provided to the office who carried out scoping work and assisted us in focussing on the implications of statutory footing.

Contribute to Departmental work on regulations for Statutory Footing.
Work continued with Sponsor Branch and wider Department of Justice partners to set regulations for the move to Statutory Footing for this office.

Address staffing implications for current PO staff.
As part of the development of the work plan, reference was made to the staffing structure, roles, skills and development needs to support the effective operation of the Office.

Deliver all aspects of the new offices remit as provided by statutory footing, including name change, rebranding and new website.
Development of a change management plan was incorporated in the work plan to take forward preparations.

Communicate to stakeholders and promote the new Office of Prison Ombudsman for Northern Ireland.

Provisions for a communication strategy were made as part of the work plan.

2. Complaints and DiC Investigations

We brought in 3 new staff and with COVID-19 became aware of the need to develop more effective induction training to cover these bases.

Produce investigation reports which are evidence-based and impartial.

Opinions about report quality are often subjective, especially if the evidence is inconclusive. However no formal complaints were lodged about the quality of our investigations or reports. When informal challenges were mounted we reviewed the evidence to ensure adherence to the Rules and Terms of Reference.

The "Lessons Learned" process to evaluate all DiC investigations and reports, as well as significant complaint investigations and reports, continued to provide a useful quality control mechanism.

Ensure full compliance with Complaints and Death in Custody Terms of Reference by Investigators.

Internal review of all DiC reports and complaint reports indicated compliance with the Terms of Reference, especially the important principles of evidence-based and impartial practice. Feedback was provided to Investigators individually and collectively in order to maintain standards and support their professional development.

Adhere to timescales (nine months for draft DiC reports and 18 weeks for final Complaints reports) in all investigations.

Not achieved - Delivering investigations in line with the performance target to issue draft reports within 9 months remains challenging for a variety of reasons including: the ability to complete interviews; receive timely responses to requests for information; delays at the factual accuracy stage; and staffing within the Office of the Prisoner Ombudsman.

Not achieved - 85% of all complaints cleared were finalised within the 18 week target. The main reasons for failing to reach this target include: delays in receiving material; accessing witnesses for interviews and receiving feedback from the Prison Service as well as significant staffing pressures.

Ensure an Investigator is on site within four hours of being notified about a death in custody.
Achieved.

Conduct a quarterly validation exercise within each prison of accepted recommendations in complaints reports.
Not achieved - Due to staffing pressures.

Dip sampling exercises carried out on internal complaints within each prison were suspended mid-year in order to review effectiveness. It was concluded that a more effective mechanism could be developed. Suspended to review.

On site clinics, initially established to assist prisoners to come forward with complaints from under-represented groups, specifically at Magilligan and Hydebank Wood College, were reviewed given staffing pressures. On assessment of the effectiveness of these mechanisms they were suspended to enable staff to focus on delivery complaints investigations.

Assess implementation of accepted Death in Custody recommendations in conjunction with other oversight bodies e.g. Independent Monitoring Boards, Criminal Justice Inspectorate, Regulation & Quality Improvement Authority and the International Committee of the Red Cross.
Not Achieved - Due to pressure of other work.

Maximise accessibility for everyone who has contact with our services. Ensure low user groups - such as female prisoners, young offenders, foreign national prisoners and visitors - have opportunities to understand the role of the Prisoner Ombudsman.
We continued to address underuse of our service by certain groups. Efforts included monthly "clinics" at Hydebank Wood for young male and female prisoners. The numbers of formal complaints from low users did not increase but we identified several local concerns and ensured prison managers were made aware of them. We continued monthly complaints "clinics" at Magilligan Prison. The increase in the number of complaints received was not significant and it was agreed that the resource it took to continue the clinics was disproportionate to the outcome so this measure was suspended.

"Inside Issues", our publication for prisoners, was prepared and circulated to every prisoner in July 2019.

3. Support for Prison Service Complaints Handling

Assist the Prison Service to improve local resolution of complaints.
Efforts continue to encourage informal local resolution through the provision of telephone advice to prisoners and taking forward issues raised at the "clinics".

Contribute to relevant consultation exercises, conferences and other events to share the findings of Complaint and DiC investigations.
No requests received. Contributions were made to 2 consultations - Sentence Review and Smoke free prisons.

4. Support for the Prison Service & SEHSCT Partnership Working

Meet monthly with the Director of the Reducing Offending Division, and quarterly with prison governors to share feedback from investigations and matters of mutual interest.
Achieved. Formal meetings with the Prison Service Director General and Prison Governors were conducted throughout the year to discuss DiC and Complaint findings, address areas of concern and recognise progress.

Meet regularly with South Eastern Health & Social Care Trust (SEHSCT) senior managers to share feedback from DiC investigations and other matters of mutual interest.
Achieved. Formal meetings with the SEHSCT Director & Assistant Director of Prison Healthcare took place on a six-monthly basis throughout the year.

Meet regularly with other stakeholders including CJI, Independent Monitoring Boards, the Coroner, RQIA, ICRC and the Northern Ireland Public Services Ombudsman to share feedback from investigations and other matters of mutual interest.
Achieved. The Prisoner Ombudsman and/or Director of Operations met these bodies regularly. NIPSO was not achieved in this year.

Contribute to the training of the Prison Service and SEHSCT staff if requested.
Achieved. The Ombudsman, Director of Operations and Senior Investigating Officers contributed to several training events for Prison Service new recruits.

5. Corporate Affairs

Prepare a 2018-2021 Corporate Business Plan (Subject to the appointment of a Prisoner Ombudsman).
Not achieved. A Four year Corporate Business Plan has not yet been achieved due to resourcing issues resulting in the re-prioritising of objectives.

Monitor our financial performance against the opening budget allocation for 2019-2020 of £648,000.
Achieved. Regular monitoring and reporting to DOJ Finance Services Division and management of finances within allocated budget with no overspend.

Publish annual report by September 2020.
Not achieved. The 2019-2020 Annual Report was not published until March 2021 due to resourcing issues and the ongoing difficulties caused by the onset of the Covid-19 pandemic.

Issue two editions of 'Inside Issues' magazine to prisoners.
Not achieved. Magazine published in July 2019.

Complaints

Context

The Prison Service Internal Complaints Process (ICP) is underpinned by a prisoners' right to lodge a complaint. While anecdotal evidence suggests that prisoners have mixed views about the effectiveness of the ICP, there would appear to be no general reluctance on the part of the adult male population to submit complaints. From the perspective of my office, an effective ICP is the first cog in a process to increase prisoner confidence that their welfare is taken seriously. When complaints escalate to my Office it is critical that investigators provide a wholly independent approach and that they take the effectiveness of the ICP into account.

Of a prison population of 1497 (1st April 2020) 5311 complaints were made, a negligible decrease from 5338 the previous year. The majority of these complaints, 76%, were closed at Stage 1. 19% were closed at Stage 2 and 5.42% were rejected or a prisoner was released. Less than 1% of complaints were outstanding at the end of March 2020. This is important as timely responses are critical to good complaints handling.

Complaints are closed for a variety of reasons ranging from prisoner satisfaction with the outcome to prisoners withdrawing their complaints. Any failure to deal with a complaint effectively can have a cost to the Prison Service as it may drive further complaints and, when coupled with dissatisfaction, prisoners can feel they are not taken seriously.

Complaints can only come to my Office when the Stage 1 & 2 internal process has completed. At that point there are a number of other avenues for redress open to prisoners, including judicial review and advocacy mechanisms such as those provided by the Independent Monitoring Boards.

Just over 6% of the overall complaints made by prisoners to the Prison Service, or 328 complaints, came to my Office.

Prison Service data for April 2019 - March 2020 shows:

- 5311 complaints were made to the Prison Service. Of complaints considered (5288):
  - 4013 (76%) were closed at Stage 1
  - 977 (19%) were closed at Stage 2
  - 288 (5.42%) were closed as rejected or upon the prisoner's release
  - 10(<1%) were still open on 31st March 2020

Separated Republican prisoners on Maghaberry Roe 3 and 4 landings lodged 235 complaints, a significant decrease of 54% on last year. The number of complaints made to the Prison Service by all prisoners (5311) was similar to last year (5338).

There are various reasons for complaints being closed. These vary from prisoners receiving a reasonable answer, through to being discharged from custody (at which point the Prison Service closes a live complaint as it feels unable to offer an effective remedy), or abandoning their complaint. Part of the explanation is however a failure to effectively deal with complaints at the first or second stages. This creates drivers for additional complaints, resulting in a real cost to overall Prison Service business; and it can indicate to prisoners that they are not being treated seriously.

Complaints only become eligible for investigation by the Prisoner Ombudsman's Office after Prison Service Stages 1 and 2 have been exhausted; and prisoners have no other means of seeking redress for their grievances: Independent Monitoring Board volunteers visit the prisons regularly and perform a valuable advocacy role which prevents several issues from developing into complaints; and many prisoners instruct law firms in Judicial Reviews. During 2019-2020 we continued our outreach efforts to ensure low user groups, such as foreign national prisoners, females and young men, were aware of our office and knew how to complain properly.

Complaints received by Prisoner Ombudsman 2019-2020

Of the 328 complaints received, the majority came from Maghaberry Prisoners as demonstrated in Table 1.

	Individual complaints 2019-2020	% of all complaints	% of overall prison population (31 March 2020)
Maghaberry	302	92%	61%
Magilligan	21	6%	30%
Hydebank Wood (young men)	4	1%	5%
Hydebank Wood (female)	1	Less than 1%	4%
Overall Total	**328**		

Given the population at Maghaberry Prison it is unsurprising that the majority of complaints should come from there. Additionally, Maghaberry Prison houses separated prisoners in Bush and Roe Houses. Prisoners in Roe 3 & 4 accounted for 163 or 50% of the complaints to the Prisoner Ombudsman's Office and in addition to these individual complaints, 205 multiple complaints were also received from separated prisoners. The number of complaints received from prisoners housed in Roe 3 & 4 saw a slight increase from the previous year, up from 149 to 163. By contrast, the number of multiple complaints fell from 1719 to 205. It remains significant and of note that less than 1% of the prison population make 50% of complaints.

The low number of complaints from Hydebank Wood, both young men and female prisoners, remains a matter of concern. The low level of complaints from young men is, however, in harmony with other jurisdictions. In addition, a decrease in complaints was noted from Magilligan. The situation will be monitored and consideration given to how the Office ensures prisoners are aware of and understand how to make a complaint to the Ombudsman, the benefits of a complaint and also to what other redress measures can be effective for those who consider the complaints process to be too long and arduous, for example local resolution mechanisms already in place within the Office.

Table 1: Individual Complaints Received by Prisoner Ombudsman 2019-2020

Location	Individual Complaints 2019-2020	Percentage of all complaints	Percentage of complaints excluding Roe 3&4	Percentage of overall prison population on 31 March 2020
Roe 3 & 4*	163	50%		<1%
Maghaberry Others	139	42%	84%	60%
Magilligan	21	6%	13%	30%
Hydebank Male	4	1%	2%	5%
Ash House	1	<1%	<1%	4.6%
Overall Total	**328**			

Integrated Prisoners

165 complaints were escalated to our office by integrated prisoners, a decrease from 259 in 2018-19. This represents only 3.1% of all the complaints that prisoners initiated via the Prison Service Internal Complaints Process.

Table 1 illustrates that 84% (139/165) of integrated prisoners' complaints to our office came from Maghaberry Prison. Like young men in custody throughout the UK, those in Hydebank Wood made little or no use of the official complaints system; and complaint rates from the women prisoners in Ash House have always been very low. Magilligan's overall total has decreased from last year remaining low.

Roe 3 & 4

Separated Republican prisoners held on Roe 3 and 4 landings at Maghaberry Prison lodged 163 individual complaints in 2019-2020, compared to 149 in the previous year. By contrast the number of multiple complaints received fell from 1719 to 205 over the same period marking a change in approach. During 2019-2020 they comprised less than 1% of the total prison population, but made 50% of the complaints that were received by our office.

Complaints handling April 2019 - March 2020

Table 2 sets out the numbers of complaints handled by the Office. It is regrettable that the % of complaints investigated decreased significantly from 81% in 2017-18 and 82% in 2018-19 to 65% in year. Reasons for this have already been identified in this report: decamping from the main office for a number of months and staffing pressures. While there is an explanation for the decrease, it is not satisfactory. It is essential that this is addressed in the incoming year.

Table 2: Complaints cleared April 2014 - March 2020

Year	Investigated & Reported	Local Resolution	Withdrawn/ Released	Total
2019- 20	134 (65%)	16 (8%)	56 (27%)	206
2018-19	275 (82%)	2 (<1%)	60(18%)	337
2017-18	252 (81%)	13 (4%)	47 (15%)	312
2016-17	220 (72%)	4 (1%)	84 (27%)	308
2015-16	1419 (92%)	31 (2%)	65 (6%)	1,515
2014-15	873 (82%)	143 (13%)	52 (5%)	1,068

A total of 206 complaints were cleared by this office during 2019-2020 (Table 2).

Table 3 provides a breakdown of outcomes for the complaints that were investigated and reported on by this office.

Table 3: Outcomes for Complaints Investigated April 2014 - March 2019

Year	Upheld	Partially Upheld	Not Upheld	Total
2019 - 20	31 (23%)	11 (8%)	92 (69%)	134
2018 - 19	49 (18%)	45 (16%)	181 (66%)	275
2017 - 18	46 (18%)	108 (43%)	98 (39%)	252
2016 - 17	39 (18%)	45 (20%)	136 (62%)	220
2015 - 16	616 (43%)	146 (10%)	657 (46%)	1419
2014 - 15	473 (54%)	173 (20%)	227 (26%)	873

The significance for complainants should not be underestimated: lengthy lockups, delayed mail and minor damage to personal possessions can have a seriously destabilising effect on prisoners who have limited opportunities for contact with their families and few personal possessions.

We made a total of 146 recommendations for improvement in response to prisoners' complaints during 2019-2020. 94% of these had been accepted with 6% rejected.

Table 4: Maghaberry Integrated Prisoners Main Complaint Topics 2014-2020

Complaints Topic	2019- 20	2018-19	2017-18	2016-17	2015-16	2014-15
Staff attitude	35	50	26	33	61	35
Accommodation	12	23	12	11	51	43
Property and Cash	18	15	24	16	32	35
Adjudications	5	15	5	7	6	6
Tuckshop	4	11	-	-	-	-
Complaint Procedure	4	9	-	-	-	-
Mail	2	8	7	4	9	3
Discrimination	2	8	2	4	7	3
Visits	5	7	7	5	15	10
Searching	4	7	2	1	6	13
Transfers/Allocation	1	6	6	7	9	12
Regime	2	6	6	7	7	4
Adverse reports	3	5	2	2	3	5
Food	2	5	-	-	-	-
Telephone	6	5	-	-	-	-
Lock down	0	4	1	7	13	12
Education	2	2	6	6	31	9
Health & Safety	3	1	3	1	12	0
Home leave	4	-	1	-	-	7
Miscellaneous	24	33	38	58	152	79
TOTAL	**138**	**209**	**148**	**169**	**314**	**276**

Prioritisation of Complaints

Complaints to this office are typically dealt with in the date order they are received. However in June 2017 we introduced a formal process whereby in certain particular circumstances complaints received could be prioritised. This is communicated to all complainants when they receive a letter from us to indicate that a particular complaint has been deemed eligible. Complainants are also advised of the criteria that we use in determining prioritisation and how to make such a request.

Complaint Case Studies

Mr A complained that he believed the food provided by NIPS did not meet halal standards.

The investigation established that the kitchen in Maghaberry can demonstrate the halal standard. Halal standard certificates from the supplier were provided to the Prisoner Ombudsman Investigator. A local Imam confirmed that he was content with the arrangements and offered to arrange to again meet with the kitchen staff in the future.

Mr A's complaint was not upheld.

Mr B complained about not being able to purchase brass knobs and other small items for his hobby work.

The investigation established that Mr B had been ordering these items for about 6 years to make jewellery boxes to raise money for cancer charities. The complaint was not answered in a satisfactory manner as he was informed his hobby items were 'no longer available in the Tuckshop.' This was misleading as a Governor confirmed that the items were withdrawn by Security.

Mr B's complaint was upheld. The Prisoner Ombudsman made the following recommendations that were accepted:

- That prisoners who show a sustained level of commitment to hobby craft work should be permitted to continue to purchase items they have purchased in the past.
- Blanket decisions regarding the safety of hobby craft items should be avoided.
- Consistent and justified reasons for withdrawing and/or forbidding the purchase of hobby craft items by Security should be taken in conjunction with consultation with landing staff about context within the individual prisoners' daily activities and behaviour.

Mr C complained about missing and damaged property.

The investigation established from tuckshop records that Mr C purchased the missing items then had to purchase them again following a move. The Prison Service state that staff packed his property. Missing property as a result of the prisoner not packing his own belongings on moving is a common complaint to the Prisoner Ombudsman.

Mr C's complaint was upheld. The Prisoner Ombudsman made the following recommendations:

- Prisoner C should be enabled to make a claim for compensation for all the items that he then had to re-purchase himself.
- Prison Service should remind staff of the importance of adhering to the internal complaints process timescales.

The Prison Service responded stating they did not accept Recommendation 1 stating *'I am unable to accept this as the Senior Officer was clear that she was present when staff packed the prisoner's property and that it was pointed out to her by staff at that time that the flask was already broken.'*

Recommendation 2 was accepted.

Mr D asked the Prisoner Ombudsman to investigate two complaints relating to:

1. Pre-release procedures
2. Case conference recording

The investigation established that the (Prisoner Development Manual) PDU manual explains the conditions of Accompanied Temporary Release/Unaccompanied Temporary Release (ATR/UTR) release. It states that a Prisoner *must* give plans for utilising his leave (mandatory).

It would be reasonable to expect that in order to do so a prisoner must contact family and friends to put arrangements in place well in advance of the temporary release date.

The investigation established that Mr D did not receive minutes on time and was not, therefore, in reasonable possession of information. The Prison Service explained the necessary procedures required for the Accompanied element of Mr Ds Temporary Release.

Mr D's complaint was partially upheld. The Prisoner Ombudsman made the following recommendations that were accepted:

- I recommend that when a prisoner applies for a combined ATR/UTR that the PDU endeavour to inform the prisoner of their decision (favourable or unfavourable) or for security reasons at least a full 24 hours prior to provisional release date to ensure that the prisoner and his family are given time to make arrangements that satisfy the conditions of his release.
- I recommend that the Prison Service ensure that a copy of Case Conference Minutes is given to the Prisoner as soon as they are available.

Mr E complained about:

1. A delay in receiving afternoon medication
2. A night guard and
3. The handling of his complaint.

Point one is outside the remit of the Prisoner Ombudsman and was investigated by the Healthcare Ombudsman.

With regard to the second point, about a night guard, the Prisoner Ombudsman investigator established that a Supporting Prisoners at Risk (SPAR) was opened following an incident of self-harm which records that Mr E harmed himself as he became frustrated at the delay in his medication. Handover journals were obtained which state 'handover to night guard-no issues'. Night Guard staff may not have been aware initially of the fact that Mr E had missed his afternoon medication and that his behaviour was a result of this. Mr E felt that a particular comment was inappropriate given his state of mind however it was not possible to prove exactly what the night guard said to Mr E.

The Prisoner Ombudsman investigator felt that the evidence suggests that when Mr E raised this complaint, although it was recorded, he was not interviewed within 24 hours. The complaint was later recorded again on the system. Reponses to both complaint were duplicated however the names of those responsible for the responses differed making it difficult to determine who investigated the complaint.

Mr E's complaint was upheld. The Prisoner Ombudsman made the following recommendations which were accepted:

- That staff are reminded of the importance of recording all incidents in all journals and on PRISM
- That staff are reminded to ensure that all complaints are recorded onto the PRISM system as soon as possible after the event and that all interviews are conducted within the guidelines contained in the NIPS Internal Complaints Process
- That all staff are reminded of the need to treat prisoners in an appropriately mature manner and be mindful of their professional responsibility as detailed in both the NIPS Suicide and Self Harm Prevention Policy 2011 and the Prison Service Code of Conduct.

Deaths in Custody

We initiated investigations into two deaths in custody and eleven post-release deaths.

Ombudsman investigations into prison deaths are part of a three-pronged process (the other elements being a police investigation and the Coroner's inquest) by which the state fulfils its duty under Article 2 of the European Convention on Human Rights. This process allows every aspect of a prisoner's death to be thoroughly explored.

During the reporting period we commenced investigations into two deaths in custody, both involving Magilligan prisoners. There were no deaths at Hydebank Wood, Ash House or Maghaberry Prison. The two deaths appeared to be from natural causes. Definite causes of death in all cases are only determined at the Coroner's inquest.

In addition eleven post-release death investigations were initiated to establish whether there was any link to the person's time in custody. Work continues on some of these investigations.

In 2019-20 we completed seven investigations and published four reports.

The published reports contained ten recommendations for improvement (five for the Prison Service, three for the Trust and two joint). Only one recommendation was not accepted by the Trust.

On 31st March 2020 there were twenty three ongoing investigations - ten death in custody, eleven post-release and two serious adverse incidents.

Comparisons

England & Wales:

The Ministry of Justice's "Safety in Custody Statistics Bulletin to June 2020" states that there were 294 deaths in prison custody in England and Wales in the twelve months to June 2020, a decrease of 5% from 309 in the previous year. Of these, 76 deaths were self-inflicted deaths, a 13% decrease from the 87 in the previous year.

Scotland:

Figures provided by the Scottish Prison Service suggest that there were 37 deaths in custody in 2019.

ROI:

The Annual Report of the Office of the Inspector for Prisons for 2018 shows that there were 16 deaths in custody from the 1st of January to the 31st of December 2018 in the Republic of Ireland. An additional 7 prisoners died while on temporary release.

Corporate Affairs

External Communication

Publication of two of the DiC reports published this year and the 2019-2020 Annual Report were accompanied by a press release and where appropriate, supplementary communications activity.

Contact was maintained with relevant bodies during the year. These included the Coroner's Service, the Regulation & Quality Improvement Authority, Criminal Justice Inspectorate and International Committee of the Red Cross.

The Ombudsman's office held a monthly stock take with the Prison Service Director-General and a quarterly stock take with the governor of each prison was also held.

"Inside Issues," a four page news sheet, was the Office's main vehicle for communicating with prisoners. It included case studies, statistics and information about the complaints process in eight languages. The summer 2019 edition was published and a copy was distributed for each person in the Prison Service custody at the time.

Finance

The Prisoner Ombudsman's opening budget for 2019-20 was £648,000. The office complies with the Treasury Corporate Code of Governance and with the principles governing relationships between departments and their arms' length bodies. To this end a Framework Document sets out the relationship with the DoJ.

They place particular emphasis on:

- The Prisoner Ombudsman's overall aims, objectives and targets in support of the DoJ's wider strategic aims, outcomes and targets contained in its current Public Service Agreement;
- The conditions under which any public funds are paid to the office; and
- How the Prisoner Ombudsman's Office is held to account for its performance.

As the Prisoner Ombudsman's Office is funded directly from the DoJ programme rather than by grant-in-aid, its expenditure is recorded as part of the DoJ departmental expenditure. This means the Prisoner Ombudsman does not produce its own set of accounts nor lay its finances before the Assembly separately from the DoJ.

Consequently financial instruments play a more limited role in creating and managing risk than would apply in a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with expected purchase and usage requirements. The office is therefore exposed too little credit, liquidity or market risk.

The Annual Finance and Governance Report for 2019-20 by the DoJ Internal Audit Unit found the Prisoner Ombudsman's showed an overall audit opinion of "satisfactory" and made two priority 3 recommendations.

In September 2015 the DoJ sponsor branch had proposed that their quarterly overview meetings with the Prisoner Ombudsman's Office be reduced in frequency to a biannual basis, as they were content with levels of assurance in place. This process was maintained throughout 2019 -20.

All proposed business changes were examined through the preparation of a business case. All procurement and contract management processes comply with UK and/or EU procurement regulations to ensure full and fair competition between prospective suppliers; and they are managed in line with Cabinet Office transparency guidelines and approvals processes. The Office Manager participates in the DoJ Procurement Forum.

Tender evaluation incorporates monetary and non-monetary factors. The Director of Operations reviews the management of supplier performance to ensure that quality and services are maintained for the duration of contracts and that evaluation takes place.

Information Security

Information Security is managed by the Director of Operations and the office is fully aligned with the DoJ Security Policy Framework. This entails quarterly Accreditation and Risk Management reports, annual Security Risk Management Overview returns and participation in the DoJ Information Security Forum and Security Branch. Staff are trained in, and required to comply with, all NICS security policies and guidance.

Risk Management and Internal Control

The Risk Register is an important method of identifying key risks and the means to manage and mitigate them. It is regularly assessed by the Management Team and a system of internal control provides proportionate and reasonable assurance of effectiveness in line with identified risks. The Management Team oversees internal controls and risk management and regularly reviews their effectiveness.

Shared Services

Several corporate services are shared:

- Payroll and Human Resources support have been provided by the DoJ HR Support and the NICS HR Connect service since April 2010;
- Finance transactional support functions have been provided via the Account NI shared service system since July 2012; and
- Retained finance functions are provided by Financial Services Division.

The Director of Operations validates expenditure requests, ensures compliance with delegated limits and segregation of duties and adherence to the Financial Procedures Manual.

Throughout the year the office has checked that its controls and processes are operating effectively, with manual checking of data integrity and accuracy where necessary, specifically in the area of travel and subsistence monitoring and other approvals which lie with the Director of Operations.