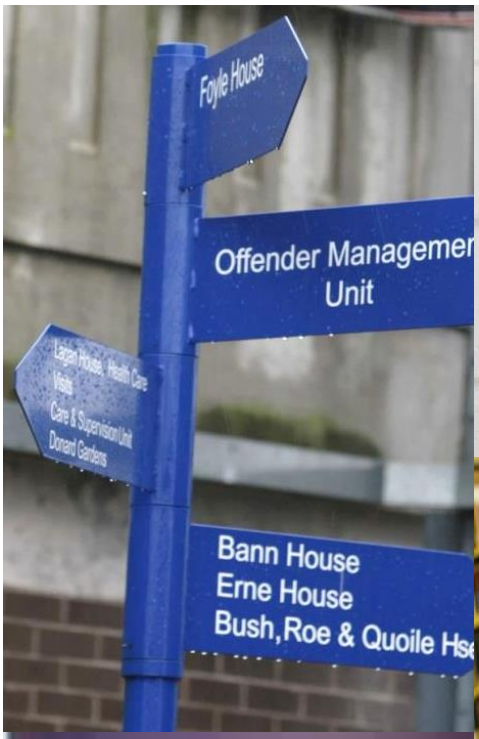
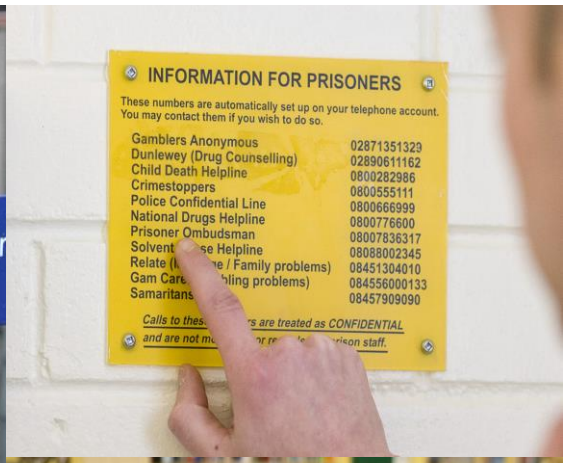
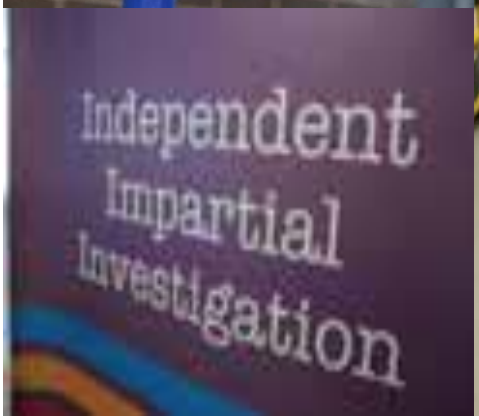
The Prisoner Ombudsman for Northern Ireland

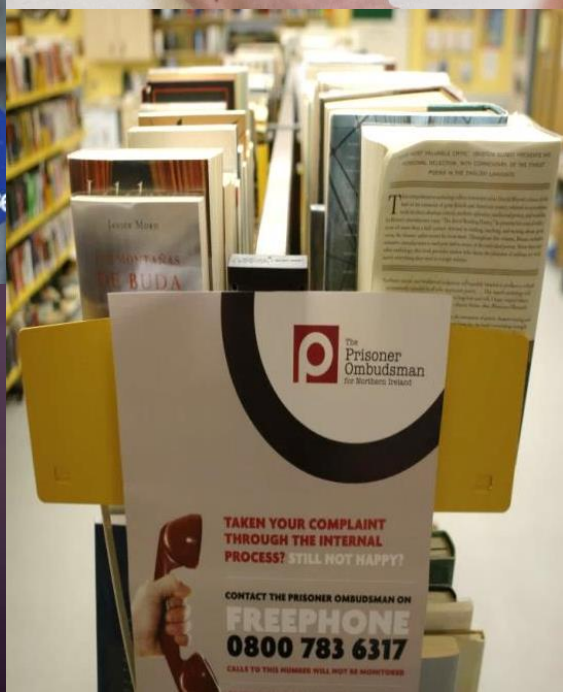
# PRISONER OMBUDSMAN FOR NORTHERN IRELAND

# ANNUAL REPORT 2017-18



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# FOREWORD

**I am pleased to present my first Annual Report as Interim Prisoner Ombudsman, which covers the period April 2017-March 2018.**

The previous Prisoner Ombudsman, Tom McGonigle, retired from post on 31 August 2017. Until his successor is appointed, the important work of the Ombudsman's Office must continue. Given the commonality of purpose between that office and Criminal Justice Inspection Northern Ireland, the Department of Justice asked me to oversee the Ombudsman's Office until a successor to Mr. McGonigle can be appointed. It is in that capacity that I publish this annual report.

Our work is entirely demand-led, which means volumes are unpredictable. During the reporting period we commenced investigations into three deaths in custody. One involved a prisoner at Magilligan and two involved Maghaberry prisoners. Two of the deaths appeared to be self-inflicted and the other appeared to be from natural causes.

The deaths occurred in in May, August and September of 2017. Follow-up activity by the South Eastern Health & Social Care Trust (SEHSCT) and the Northern Ireland Prison Service (NIPS) to support other prisoners and staff was prompt and appropriate.

We made 9 recommendations for improvement in the two death in custody (DiC) reports that were published, all of which were accepted by the NIPS and the SEHSCT.

We received 1,953 complaints, a 55% decrease on last year. Only 167 of these came from integrated prisoners and the others were complaints from separated prisoners on Roe 3 and 4 landings at Maghaberry prison. The reduction in integrated prisoners' complaints was commensurate with a lower prison population. It may also be partially explained by a more stable regime in Maghaberry where the vast majority of complaints originate.

We made 134 recommendations for improvement in relation to prisoners' complaints. At the time of writing 76% of these had been accepted by the NIPS.

The process for placing this office on a statutory footing progressed through the Northern Ireland Assembly and the Justice (No 2) Bill received royal assent on 12th May 2016. It was therefore disappointing that underpinning Regulations could not be completed before dissolution of the Assembly on 26th January 2017.

There were significant changes of personnel during 2017-18 although our investigative staff capacity remained fairly stable throughout. By March 2018 the team was at full strength with only the post of Prisoner Ombudsman remaining vacant.

Concerns were highlighted last year about inordinate delays in receiving material for investigations and factual accuracy responses from the NIPS and SEHSCT. Responses from the NIPS have become better, but timeliness remains an ongoing challenge for the Trust.

I would like to place on record my appreciation for the continued cooperation received from the NI Prison Service, the South Eastern Health & Social Care Trust, the Department of Justice and the Coroners Service. I am especially grateful to everyone in the Prisoner Ombudsman's Office for their contribution throughout the year.

Brendan McGuigan
Interim Prisoner Ombudsman for Northern Ireland

September 2018

## 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. Inter alia it suggested that 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 NIPS to investigate deaths in prison. He does not have any statutory powers in this matter.

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 NIPS and SEHSCT, on the basis that we all share the common aim of improvement. Draft Death in Custody reports are shared with the NIPS, 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 the NIPS and complainants to ensure factual accuracy; and we ask the NIPS 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.

## 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 NIPS 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 previous Prisoner Ombudsman – Tom McGonigle – retired from post on 31 August 2017. In the absence of a Justice Minister to appoint a successor, Brendan McGuigan (Chief Inspector, Criminal Justice Inspection Northern Ireland) was asked by the Department of Justice to oversee the Ombudsman's Office in the interim.

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 in the delivery and management of investigations, and deputises for the Ombudsman in his absence. The Director of Operations is also the Chief Executive and Accounting Officer, and therefore 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. He 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 sponsoring Division of the DoJ (Policing Policy & Strategy Division/Probation and Prisoner Ombudsman 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 2018 the staff complement comprised 11 people:

- Prisoner Ombudsman (Post currently vacant)
- Director of Operations
- 2 x Senior Investigators
- 5 x Investigators; and
- 2 x Administrative Support staff.

There were some staff changes during the year: the retirement of the Prisoner Ombudsman in August 2017; and two new investigators appointed. While the DoJ maintained the office's overall headcount, we had to manage substantial gaps between people leaving and their replacements arriving, who then required a period of induction.

The Prisoner Ombudsman is a public appointee and all other staff are established civil servants.

New Investigators spent time with the NIPS as part of their induction. This has proven to be a useful practice, with the emphasis on learning about Prison Service processes such as adjudications, home leave decisions and prisoner safety meetings. All staff also undertook the full range of Northern Ireland Civil Service (NICS) required training during 2017-18, much of which was delivered online.

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.

## Finance

The 2017-18 opening budget was £575,000, of which 90% was spent on salaries. The Prisoner Ombudsman retained independent legal and public relations advice, and commissioned clinical reviews, transcription and translation services from within this budget.

## Corporate and Business Planning

A Business Plan for 2017-18 was published in June 2017, setting out more precisely the annual objectives and resources to be employed to achieve them. A three-year Corporate Plan will be produced once a new Prisoner Ombudsman has been appointed.

## Management Commentary

### Statistical Headlines for 2017-18

- **Investigations initiated into the deaths of 3 prisoners and 5 ex-prisoners**
- **2 investigations completed by the DiC team and 2 reports published**
- **9 recommendations for improvement made in DiC reports of which 100% were accepted**
- **1,953 complaints received, a decrease of 55% from 2016-17**
- **89% of integrated prisoners' complaints came from Maghaberry**
- **61% of complaints were Upheld or Partially Upheld**
- **99 recommendations for improvement were made in complaints reports of which 78% were accepted at time of writing**

### Performance against targets 2017-18

***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;

Contribute to the Department of Justice Statutory Footing Working Group;

Address the implications for current PO staff;

Deliver all aspects of the new offices remit as provided by statutory footing, including name change, rebranding and new website;

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

*The Justice [No.2] Bill received royal assent on 12th May 2016. Work on the Regulations commenced in June 2016 and continued through to the early part of 2017-18 when it was suspended pending the return of the NI Assembly and the formation of a Justice Committee.*

## 2. Complaints and DiC Investigations

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 dip samples of 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.*

*54% 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 NIPS.*

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

Conduct dip samples in each prison of accepted recommendations made in complaint reports.
*Achieved – A quarterly validation of accepted recommendations was undertaken with the full cooperation of NIPS.*

Conduct dip samples in each prison of complaints that were finalized at internal NIPS Stages 1 & 2.
*Achieved – Dip sample exercises were completed as planned at both Hydebank Wood and Magilligan.*

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 foreign national prisoners, young offenders 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 introducing 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.*

*"Inside Issues" was prepared and circulated to every prisoner in July 2017 and January 2018.*

## 3. Support for NIPS Complaints Handling

Assist the NIPS to improve local resolution of complaints. In 2017-18 this will include comparison against previous years.

*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.

*The Office of the Prisoner Ombudsman provided input into the Prisons 2020 consultation exercise.*

## 4. Support for NIPS & SEHSCT Partnership Working

Meet monthly with the NIPS Director General, and quarterly with prison governors to share feedback from investigations and other matters of mutual interest.

*Formal meetings with the NIPS 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.

*Formal meetings with the SEHSCT Director & Assistant Director of Prison Healthcare took place on a quarterly 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.

*The Prisoner Ombudsman and Director of Operations met these bodies regularly, and also with others such as the International Committee for the Red Cross and international visitors.*

Contribute to the training of NIPS and SEHSCT staff if requested.

*The Director of Operations contributed to several training events for NIPS new recruits.*

## 5. Corporate Affairs

Prepare a 2018-2021 Corporate Business Plan
*Production of a three year Corporate Plan is on hold awaiting the appointment of a Prisoner Ombudsman.*

Adapt to budgetary reductions and associated changes;
*Our budget was not reduced this year and expenditure remained within allocated parameters.*

Prioritise investigative capacity in event of further staff changes;
*Achieved – Significant changes of personnel at Investigating Officer level contributed to compromising the timeliness of Death in Custody investigations. However it was helpful that the DoJ agreed to some flexibility with our investigative capacity in order to mitigate against this.*

Communicate implications of staff changes clearly to all stakeholders.
*Achieved – Primarily via the Annual Report and "Inside Issues" biannual newsletter for prisoners, as well as meetings with prisoners, their families and other stakeholders.*

Publish annual report by September 2018.
*Achieved – The 2016-17 Annual Report was published in June 2017.*

Issue two editions of 'Inside Issues' to prisoners.
*Achieved.*

# Complaints

## Context

Independent investigation of complaints can help instil in prisoners greater confidence that their welfare is treated seriously. It can also help reduce tension and promote better relations. The NIPS Internal Complaints Process (ICP) is underpinned by 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.

On 1st April 2018 there were 1,475 people in the three prisons in Northern Ireland. NIPS data for April 2017 – March 2018 shows:

7,797 complaints were made to the NIPS, of which:

- 4,349 (56%) were closed at Stage 1
- 2,746 (35%) were closed at Stage 2
- 629 (8%) were closed as rejected or upon the prisoner's release
- 73 (1%) were still open on 31st March 2018

Separated Republican prisoners on Maghaberry's Roe 3 and 4 landings lodged 2,727 complaints, a significant decrease of 50% on last year and just over one third of all complaints. The number of complaints made to the NIPS by other prisoners (5,070) reduced - by 11% - from last year (5,727). This reduction was commensurate with a lower prison population. It may also be partially explained by a more stable regime in Maghaberry; and by improvement in complaints-handling there during the reporting period.

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 NIPS 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 NIPS 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 NIPS Stages 1 and 2 have been exhausted; and prisoners have 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 2017-18 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.

*Table 1 – Complaints Received by Prisoner Ombudsman April 2017 – March 2018*

| Location | Total Complaints | Percentage of all complaints | Percentage of complaints excluding Roe 3 & 4 | Percentage of overall prison population on 31 March 2018 |
|---|---|---|---|---|
| **Roe 3 & 4** | 1,786* | 91% | - | 1% |
| **Maghaberry Others** | 148 | 8% | 89% | 59% |
| **Magilligan** | 18 | 1% | 10% | 29% |
| **Hydebank Wood** | 0 | - | - | 7% |
| **Ash House** | 1 | - | 1% | 5% |
| **Overall Total** | 1,953 | | | |

**This total includes 67 individual complaints*

**Integrated Prisoners**

167 complaints were escalated to our office by integrated prisoners, a decrease from 202 in 2016-17. This represents only 2% of all the complaints that prisoners initiated via the NIPS Internal Complaints Process. 93% of the complaints that were escalated to us were made by sentenced prisoners and only 7% by remand prisoners.

Table 1 illustrates that 89% (148/167) 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 also remained low, reflecting the more stable population held there and an increased emphasis on local resolution before complaints were escalated to us.

We conducted dip samples of complaints that were closed by the NIPS at Stages 1 & 2 of their Internal Complaints Process at Hydebank Wood/Ash House and Magilligan during 2017/18, in order to assess whether those complaints had been dealt with fairly and an adequate response provided to the complainant. 62% of Magilligan complaints and approximately 70% of Hydebank complaints were deemed to have been dealt with appropriately, with evidence of a proper investigation and adequate response. However in both instances there was evidence of significant flaws within the internal complaints process with a total of fourteen recommendations for improvement made.

**Roe 3 & 4**

Separated Republican prisoners held on Roe 3 and 4 landings at Maghaberry Prison lodged considerably fewer complaints in 2017/18, 1,786 compared to 4097 in the previous year; and they routinely refused to accept NIPS responses at Stages 1 and 2. During 2017-18 they comprised approximately 1% of the total prison population, but made 91% of the complaints that were received by our office.

The Fresh Start initiative recommended in June 2016 that an independent review of the conditions of separation should be conducted and appropriate education and training opportunities should be provided to separated prisoners. However that review had not commenced by the end of March 2018.

***Table 2 – Complaints cleared April 2013 – March 2018***

| Year | Investigated & Reported | Local Resolution | Withdrawn/ Released | Total |
|---|---|---|---|---|
| 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 |
| 2013-14 | 378 (81%) | 58 (12%) | 32 (7%) | 468 |

A total of 312 complaints were cleared by this office during 2017-18 (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 2013 – March 2018***

| Year | Upheld | Partially Upheld | Not Upheld | Total |
|---|---|---|---|---|
| 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 |
| 2013-14 | 216 (57%) | 26 (7%) | 136 (36%) | 378 |

Most of the complaints that we upheld were of a procedural nature and there were few serious allegations. However 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 134 recommendations for improvement in response to prisoners' complaints during 2017-18. At the time of writing 76% of these had been accepted, 9% rejected, and 15% were awaiting a decision from the NIPS.

*Table 4 – Maghaberry Integrated Prisoners Main Complaint Topics 2013-18*

| Complaints Topic | 2017-18 | 2016-17 | 2015-16 | 2014-15 | 2013-14 |
|---|---|---|---|---|---|
| **Property and Cash** | 24 | 16 | 32 | 35 | 48 |
| **Visits** | 7 | 5 | 15 | 10 | 46 |
| **Staff attitude** | 26 | 33 | 61 | 35 | 46 |
| **Accommodation** | 12 | 11 | 51 | 43 | 41 |
| **Adjudications** | 5 | 7 | 6 | 6 | 15 |
| **Mail** | 7 | 4 | 9 | 3 | 21 |
| **Searching** | 2 | 1 | 6 | 13 | 21 |
| **Transfers** | 6 | 7 | 9 | 12 | 19 |
| **Health & Safety** | 3 | 1 | 12 | 0 | 18 |
| **Access to regime** | 6 | 7 | 7 | 4 | 15 |
| **Home leave** | 1 | - | - | 7 | 15 |
| **Lock down** | 1 | 7 | 13 | 12 | 14 |
| **Discrimination** | 2 | 4 | 7 | 3 | 13 |
| **Education** | 6 | 6 | 31 | 9 | 12 |
| **Adverse reports** | 2 | 2 | 3 | 5 | 10 |
| **Miscellaneous** | 38 | 58 | 152 | 79 | 96 |
| **TOTAL** | 148 | 169 | 314 | 276 | 450 |

## 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 exceptional 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. In 2017-18 we received ten requests for prioritisation, seven of which were accepted.

## Complaint Case Studies

### Support to Address Gambling Addictions

**Mr. A** complained that he was unable to access a Gamblers Anonymous (GA) programme in Magilligan.

We recommended the NIPS should pursue all available options to address gambling addictions, including Freephone counselling and GA appointments during resettlement leave.

**Magilligan subsequently introduced a pilot scheme whereby prisoners could enrol for a monthly contact class with GA and arrange follow up appointments.**

### Allegation of Assault by Staff

**Mr. B** alleged he had been assaulted by staff.

We did not find evidence to uphold the complaint. However we found that staff did not follow the procedures properly - as detailed in Governor's Orders - during the internal investigation, and recommended that be addressed. **The recommendation was accepted by the NIPS.**

### Delay in Responding to Issues Raised at a Prisoner Forum

**Mr. C** complained about delay in responding to issues that were raised at a Prisoner Forum.

We upheld his complaint and recommended the Governor of Maghaberry should ensure that Prisoner Forums are meaningful and prompt responses are provided to issues that are raised by participants. **The recommendation was accepted by the NIPS.**

### A Missing Watch

**Mr. D** complained about a missing watch**.**

We tracked down the watch and recommended it should be returned to Mr. D and recorded on his property card.

**The NIPS accepted our findings and said the Unit Manager in charge of Reception would ensure that the recommendation was carried out.**

### Handling of Complaints (Magilligan)

**Mr. E** complained about how his complaints were handled at Magilligan.

We upheld his complaint and made the following three recommendations:

- For the NIPS to apologise to Mr. E, as each investigation demonstrated a lack of understanding of the Internal Complaints Process.
- For NIPS staff to be instructed that they should not provide written responses to complaints when they themselves are the focus of the complaint.
- For the NIPS to deal sensitively and quickly with complaints that allege intimidation by staff.

**All three recommendations were accepted.**

### Attending Court when on Dirty Protest

**Mr. F** complained about not being offered a shower - while he was on dirty protest - before going to court from Maghaberry.

We recommended the NIPS Dirty Protest and Faecal Contamination Policy should be updated (it dated from 2011) to provide that a prisoner who has engaged in any form of dirty protest should be offered a shower before a court appearance or any activity outside the prison.

**The NIPS agreed and said the policy would be referred to NIPS Headquarters for updating and in the interim a Notice to Staff would be issued. The policy was updated and re-issued by NIPS in September 2017.**

### Unprofessional Conduct by Officers

**Mr. G** complained that an officer deliberately sprayed him with air freshener. The NIPS did not substantiate the complaint. The Ombudsman's Office considered other evidence available, as NIPS made no attempt to seek witnesses other than staff and considered a very narrow time period.

The Ombudsman's Office upheld the complaint.

**NIPS accepted recommendations to:**

- **Utilise CCTV cameras and retain all CCTV footage relevant to a complaint or investigation.**
- **To remind staff of their responsibility to meet high standards of personal conduct in their treatment of students, as detailed in Prison Rules and the Prison Service Code of Conduct**.

### Prisoner Care during Extended Lockdowns

Prisoners complained that they were locked in ablutions for over eight hours and were not offered food, water or a return to their cell. NIPS said that while locked as described, the prisoners were offered all three.

We upheld the complaint as it would be unhygienic to offer food and water when in ablutions.

**NIPS accepted a recommendation that during periods of extended lock down, prisoners detained in areas with limited facilities will be given the opportunity to be moved to a more suitable location, and such offers fully recorded.**

### Delay in Daily Delivery of Newspapers

**Mr. H** complained that on three occasions he received his newspaper a day late. The investigation established this was true and that a daily paper was the service Mr. H had paid for. NIPS advised that staff shortages were the reason for the delay, as staff were moved from their planned duties which subsequently affected deliveries.

The Ombudsman's Office considered it unacceptable that a prisoner makes arrangements for a daily newspaper but receives it a day late, so recommended that NIPS prioritise the delivery of newspapers to ensure that prisoners who pay for the daily service receive their papers daily.

**NIPS did not accept the recommendation and provided the reason that they endeavour to ensure all facilities are maintained, and to deliver a full regime for all prisoners. This comes with recognition that at times some areas will have staff withdrawn to support the residential regime, ensure unlock during the day and provide Visits, Education, Work and other constructive activity. NIPS said the redeployment of staff is carefully considered on a daily basis and to prioritise an area as recommended would potentially adversely impact on regime delivery for all, including those who order newspapers and those who don't. They added all prisoners have access to television and radio, so there is no impediment to keeping up with current affairs.**

### Alleged Injury during Full Body Search

**Mr. I** made a complaint in which he alleged that:

- During a Full Body Search his back was injured.
- After the search was complete, he did not receive any help from either prison or Healthcare staff, to get off the floor and get dressed.

The Ombudsman's Office viewed the CCTV footage of the search, reviewed all the associated records and interviewed both prison and healthcare staff.

CCTV footage showed:

- No significant use of force by prison staff.
- No indication of injury or pain during the search.
- That when asked, Mr. I told Healthcare staff that he was able to get up.

It was not possible to evidentially conclude that injury resulted from that search. The complaint was not upheld.

**NIPS rejected the recommendation to review their FBS policy in regard to assisting prisoners who are having difficulty getting up and dressing themselves after a search has been carried out. NIPS explained that they were unable to accept the recommendation as Mr. I told the nurse that he could get up and also because any officer or Healthcare staff will aid any person having difficulty.**

### Availability of Art Materials

**Mr. J** complained about the process for ordering art materials.

NIPS identified a risk which it minimised by changing the procedure for ordering art material. However the change inadvertently had a negative impact on those prisoners undertaking formal qualifications, including A-Level Art. NIPS then consulted with Learning and Skills, and Belfast Metropolitan College.

**The complaint was upheld and NIPS accepted a recommendation that, in consultation with the Belfast Metropolitan College, they would introduce a system for prisoners undertaking formal education, to make the regular necessary art purchases required for their studies.**

### Inappropriate Comments by an Officer

**Mr. K** complained that an officer made an inappropriate comment to him.

The Ombudsman's investigation established that:

- The comment was about the use of force.
- NIPS had confirmed in their response that the comment had been made.
- The officer considered Mr. K had accepted their conversation was banter.
- A Governor had apologised for the offence this comment had caused and spoke to staff about the care needed in regard to such comments.

**NIPS accepted the recommendation that all staff are reminded of the need to ensure that all engagement with prisoners meets the standard of professional responsibility expected as detailed in Prison Rules and the Prison Service Code of Conduct.**

## Deaths in Custody

***We initiated investigations into three deaths in custody and five 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 three deaths in custody. One involved a prisoner at Magilligan and two involved Maghaberry prisoners. There were no deaths at Hydebank Wood or Ash House. Two deaths appeared to be self-inflicted and the other appears to be from natural causes. Definite causes of death in all cases are only determined at the Coroner's inquest.

In addition there were five post-release death investigations initiated. Each post-release death was subject to a preliminary investigation to establish whether there was any link to the person's time in custody.

We completed three investigations into deaths in custody and we published two reports.

The published DiC reports contained 9 recommendations for improvement (2 for the NIPS and 7 for the SEHSCT. All of our recommendations were accepted.

On 31st March 2018 there were twelve ongoing investigations – eight death in custody and four post-release.

### Comparisons

The Ministry of Justice's "Safety in Custody Statistics Bulletin to December 2017" states that there were 295 deaths in prison custody in England and Wales in the twelve months to December 2017, down 17% from 354 in the previous year. Three of these were homicides, the same number as the previous year. There were 70 self-inflicted deaths, down from 122 in the previous year.

Figures from the Scottish Prison Service indicate that there were 29 deaths in prison custody in 2017, one more than in 2016. In the Republic of Ireland figures from the Annual Report of the Office of the Inspector of Prisons for 2015 and 2016 show there 15 deaths in custody in 2015 and 5 in 2016.

# Corporate Affairs

## External Communication

Publication of one of the DiC reports published this year and the 2016-17 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 met local political representatives in relation to prison issues; a monthly stock take with the NIPS Director-General and a quarterly stock take with the governor of each prison was also held.

The Prisoner Ombudsman and Director of Operations were regular visitors to the prisons, where they met prisoners individually and collectively. They also met with prisoners' families.

*"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. Summer and Winter 2017/2018 editions were published and a copy was distributed for each person in NIPS custody at the time.

## Finance

The Prisoner Ombudsman's opening budget for 2017-18 was £575,000. 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 Management Statement and Financial Memorandum govern 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 to little credit, liquidity or market risk.

The Prisoner Ombudsman is committed to the prompt payment of bills for goods and services received in accordance with the Confederation of British Industry's Prompt Payers Code. During the year ending 31st March 2017, 86% were paid within the 10-day timeframe.

The annual Finance and Governance report for 2017-18 by the DoJ Internal Audit Unit found the Prisoner Ombudsman's performance provided "Substantial Assurance" and made one minor recommendation.

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 2017-18.

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 Director of Operations 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. A civil action which involved a data incident was settled during the year without admission of liability. 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;
- 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.

The Prisoner Ombudsman for Northern Ireland

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