ANNUAL REPORT 2022-23

The Prisoner Ombudsman for Northern Ireland

Contents

Foreword

This Annual Report represents a year in which the Office began to turn its attention to improving standards within the Office. I am very conscious that it has been challenging year for staff with the improvements to process and ongoing discussions, which will continue into the next reporting year, about what is required to support Investigators to deliver investigations to the highest standards possible.

Revised and updated Terms of Reference for the investigation of complaints have placed the Office on a stronger foundation as it moves towards Statutory Footing. The level of scrutiny required has been a challenge and I am grateful to senior staff in particular for their work in this area and to legal advice provided by Jones Cassidy Brett. I had hoped to complete a similar review of Terms of Reference for the investigation of deaths in custody but have not been able to achieve this in year.

One of my concerns is over the year has been the way in which information about the work of the Ombudsman's Office is published. Death in Custody reports are published on the website. Complaints reports are not. There is a vast mine of data and evidence available within the Office which, in my view, is not being put to good use and it would improve the impact the Office can make if themes were drawn out from all investigations and if more regular reporting of issues raised by complainants were placed in the public domain. I will give consideration to this in the year ahead.

I had hoped that in year it would be possible to more fully develop reporting about issues raised by complainants. Having completed some guidance work in this regard the Office was not able to resource the approach. While this is disappointing I hope that the possibility can be realised in the year ahead.

The Office continues to recover from the impacts of Covid-19 and that journey will continue for some time. I am concerned that stress is evident among staff and over the year I have attempted to listen carefully to the impacts on them. I have previously spoken about these matters in other places and it is important that consideration is given to building efforts into the daily workings of the Office to enable individuals to identify where stress is impacting them and that the Office provides ongoing, proactive support. Deliberateness and intentionality is required within a system that prefers to take a responsive rather than a proactive approach. I continue to work for improvement in this regard.

I am particularly grateful for the opportunities I have to work alongside prisons to improve the care they provide to those in custody. I have been privileged to get to know the working of our prisons in detail and to witness the dedication of Prison Officers who face more challenges than widely understood. Improvement within the prison system should result in a better environment for all while upholding the standards of good practice and human rights that those in custody have the right to expect. Prison Service Headquarters along with Governors and others across all establishments have worked cooperatively with me to improve how complaints are handled and the treatment of those in custody given the consideration and priority it deserves. I express my gratitude to the Prison Service for their collaborative approach.

The South Eastern Health & Social Care Trust (the Trust) is my other key partner. It has been a difficult time for healthcare and the situation is likely to continue to be challenging in the year ahead. I am grateful to have witnessed dedicated staff on the ground across our prisons and I express my gratitude to them for cooperating with investigations.

During the year one of my ambitions was to build new and stronger relationships to ensure more strategic recommendations from investigations. This ambition was focussed on delivering the kind of improvements that will make a difference to those in custody and provide assurance to the relatives of those who live with the experience of a loved one in custody. I have also been keen to improve how recommendations are made because of the difficult experience families have when they lose a loved one while they are in custody. As people in the care of the State it is important that I not only investigate robustly but also that I assure families and the wider public that everything is done that can be done to take care of people in custody. To that end I am grateful for the ongoing relationships with partners, for the re-formed relationship with RQIA and the new relationship with Commissioners of Healthcare in Prisons. The understanding that ensues from these relationships bring insights that enable me to recommendations more focussed on delivering change.

Finally, I am grateful to all of those who have been in contact with the Office. I have not been able to deliver investigations in the timely way I would like and as the year draws to a close there is a significant backlog of complaints and a staffing gap in the Death in Custody team. This will have lasting impacts into the year ahead and I look to the Office and the Sponsor Team for the support required to steady the Office and bring it to a place from which it can deliver what those who come to us should expect – professionalism, independence, timeliness and thorough investigations that provide assurance about the care provided within the prison system.

LESLEY CARROLL
Prisoner Ombudsman for Northern Ireland
May 2024

Background

The Prisoner Ombudsman's Office was established in 2005 following the Steele Review of prisons, which was commissioned because of concerns about the safety of staff and individuals in custody 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."*

The Prisoner Ombudsman's Office was established to contribute to ensuring safety and good standards within prisons through two specific functions:

- Investigate and report on Complaints from current or former individuals in custody and their visitors; and
- Investigate and report on deaths in custody including Post Release deaths (normally occurring up to 14 days post release) and Serious Adverse Incidents (SAIs).

The Prisoner Ombudsman's powers regarding investigation of complaints 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 custody. In addition, the Ombudsman may investigate some post-release deaths (normally occurring within 14 days of release from prison) and serious adverse incidents occurring within prisons.

The Prisoner Ombudsman does not currently have any statutory powers.

All investigations are guided by *The Principles of Good Complaints Handling* which are:

- Clarity of Purpose
- Accessibility
- Flexibility
- Openness and Transparency
- Proportionality
- Efficiency
- Quality Outcomes

Terms of Reference govern investigations and can be found on the Ombudsman's website niprisonerombudsman.gov.uk.

Detailed handbooks are available to guide staff in the course of their investigations. These are updated as necessary and are supported by a variety of standardised templates and guidance to ensure impartiality and thoroughness.

One of the most productive ways to promote improvement is by working in collaboration with the Prison Service and the Trust on the basis that we all share the common aim of delivering improvement. Draft Death in Custody reports are shared with the Prison Service, the Trust and the next of kin for comment and final reports are sent to the Minister of Justice and the Coroners' 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 redact dates or other identifying information before a report is published.

Draft complaint reports are shared with complainants and the Prison Service to ensure factual accuracy and we also ask the Prison Service to share draft reports with any identifiable staff who are subject to criticism. Complaint reports are not currently published.

In line with *The Framework Document* agreed with the Department of Justice (DOJ) this Annual Report provides a summary of the number of complaints received and answered along with information about what the Office has achieved in regards to completing investigations. In order to give insight into the issues raised through the complaints process, this report provides anonymised examples of responses to complainants and examples of recommendations made. Finally, the Annual Report provides a summary of costs to the Office for 2022-23.

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 Trust 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

General

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

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 Prisoner Ombudsman's Office aims to conduct itself according to standards that set out the agreed way of conducting investigations and administrative tasks to ensure that we all work more efficiently and effectively. Our values and principles relate to how we approach work and relationships, both inside the Office and with our partners and stakeholders.

The terms and conditions of staff members are the same as those for the mainstream NICS and the health and wellbeing of staff remains a 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.

The Acting Director of Operations and two Deputy Principals provide the Ombudsman with monthly updates on current investigations, budget expenditure, risk assessments 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 Executive through the Minister of Justice, and acts independently of the Prison Service. The Ombudsman meets regularly with the Prison Service and also with the Trust in respect of Death in Custody investigations.

Corporate Governance is delivered through quarterly formal governance meetings between senior staff (not the Ombudsman) and the Justice Sponsorship Branch, at which key corporate documents and processes are reviewed. Financial probity is overseen by the DOJ Internal Audit Unit in relation to which there were no recommendations arising from the audit carried out in December 2022. The Office prepares an Annual Report which is published after the end of each financial year on the Ombudsman's website. The Acting 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.

Budget Allocation

The absence of a sitting Northern Ireland Executive meant that for 2022-23 an opening budget allocation could not be set as normal. Instead, a Contingency Planning Envelope was allocated for Non-ringfenced Resource DEL of £810,000 and Capital DEL of £4,000. A final Budget Allocation for Non-ringfenced Resource DEL of £851,000 and Capital DEL of £4,000 was confirmed in December 2022.

Strategic and Business Planning

A 2020-2024 Strategic Plan sets out the vision for the Office and focuses on the following four key priorities:

- Improve investigative processes
- Safeguard and reinforce independence
- Prepare for and implement Statutory Footing
- Develop a learning environment that puts evidence to work

The 2022-2023 Business Plan which supports these priorities was published in October 2022.

Business Continuity

Public Health Agency guidelines and NICS guidance continue to be followed in relation to any reported instances of Covid-19 within the Office.

Hybrid working arrangements remain in place with a requirement for most staff to be Office based at least 2 days a week. As maintaining the Freephone is a priority, staff with responsibility for manning this phone are, of necessity, mainly Office based.

As with last year, ongoing staff resourcing issues and lack of investigative experience within the Office, hampered progress in relation to reducing the current backlog of investigations.

A key aim this year had been to ensure that we would get the Office into a state of readiness to achieve Statutory Footing by early 2024. This work included the development and implementation of a new case management system. However, to ensure that our needs could be met, we also looked at alternatives including the development of a bespoke database. Whilst the latter was considered to have been a positive solution unfortunately, no further progress has been made in this regard.

Staffing

At 31 March 2023 the staff complement comprised the following:

- Prisoner Ombudsman;
- Acting Director of Operations (Grade 7);
- Senior Investigations Officer (Deputy Principal);
- Corporate Governance (Deputy Principal);
- 7.1 Investigations Officers (Staff Officer); and
- 3.4 Administrative Support staff (Executive Officer II and Administrative Officer).

The Complaints team welcomed 2 new Investigation Officers (in July and October 2022) which brought the team up to full complement. Despite this however the team continued to be affected by the long-term absence of one investigator.

The Office Manager transferred across to the Death in Custody team in October 2022 after a previous Investigator left the Service. This transfer also brought the team up to full complement.

The recruitment of a new Senior Investigation Officer allowed the Office to reconfigure roles and responsibilities at this grade with a view to distinguishing Governance work from Investigations management. A key aim of separating the work was not only to prepare the Office for Statutory Footing by January 2024 but also from an investigations perspective, to move a position where Investigators could carry out any type of investigation.

The work of the Administration team was particularly impacted by a combination of vacancies and long-term absences with the team all but depleted from October 2022 onwards for the rest of the year. The greatest pressure has been with difficulties in recruiting staff to this team. By way of example; a part-time officer was promoted in situ to Office Manager in October 2022 and their previous post remains vacant. A second part-time officer went on a career break in November 2022 and a third officer has been on long term absence since this time also.

The impact on the business has been significant as currently there is only one part-time member of staff managing admin processes. This position is simply not sustainable hence the requirement for Investigators to carry out more administrative tasks to ensure business objectives are achieved.

In January 2023 the Acting Director of Operations was also given responsibility for managing an Independent Monitoring Board Secretariat which comprises two staff. The appointment of a substantive Director of Operations remains outstanding but an appointment is expected in the next reporting period.

Further details of the workloads carried by both teams are outlined below.

Training

All new staff undertook extensive in-house training which was consolidated by support from experienced Investigation Officers.

In addition, the majority of investigation staff completed their specialist investigative training with the external provider, Bond Solon, and all those who participated attained an Advanced Professional Certificate in Investigative Practice. Arrangements will be made for those yet to complete the training to be given the opportunity to do so.

Performance Overview

- By the end of the year, the backlog of complaints had not reduced. In-year reduction was happening but as the year ended a significant number of complaints were received unexpectedly and in a format not previously seen by the Office. This is regrettable. In April 2022, 281 complaints were awaiting investigation and at the end of March 2023 there were 393.
- Investigations initiated into the deaths of 11 individuals in custody and 1 Serious Adverse Incident.
- 6 Death in Custody investigations were closed and 5 reports published.
- 18 recommendations for improvement were made in Death in Custody reports, of which 16 were accepted.
- 394 individual complaints were received which is a slight increase on the number of complaints received when compared to 2021-2022 (363). Additionally, 43 complaints were considered ineligible for investigation.
- 321 (81%) of complaints came from Maghaberry Prison. Of these 217 (55% of all complaints) were received from Roe House 3 & 4 separated landings. One complaint was received from Bush House separated landings.
- 6 (6%) out of 124 complaints investigated were Upheld.
- 9 recommendations for improvement were made on the outcome of Complaints investigations of which 4 were accepted.

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.

One of my key aims for the year was to ready the Office for Statutory Footing and it remains a frustration that ongoing resourcing difficulties and operational priorities hindered full achievement of that goal. In October 2022, the Complaints Senior Investigations Officer took on a new role as a DP Governance Officer with specific responsibility for progressing the Statutory Footing Action Plan however progress has been limited. The Terms of Reference for the Investigation of Complaints was updated and published in August 2022. Work remains ongoing in relation to updating the Terms of Reference for Deaths in Custody and this will be finalised in the next reporting period.

I reported last year that I believed effective digitisation will greatly assist in the delivery of Statutory Footing and this view remains. A new case management system was originally proposed however, an alternative solution, specifically a bespoke database, was identified by developers as potentially better to meet our needs. To date, this area of work has stalled with no further progress achieved.

Contribute to Departmental work on regulations for Statutory Footing.
As with last year this work has stalled, but we remain committed to working with the Department to set regulations for the move to Statutory Footing.

Address staffing implications for current Prisoner Ombudsman staff.
Assessing the staffing structure, roles, skills and development needs required to support the effective operation of the Office in preparation for Statutory Footing is an area of work that is ongoing. While the governance work has stalled due to capability challenges there has been an ongoing, slow and steady focus in improving investigative standards, training, recording and practice that is focussed on contributing to readying the Office for statutory footing. This will be a critical focus in the year ahead.

Not achieved. It is disappointing to report that the Inside Issues magazine did not publish during 2021-2022; this was due to focusing on other competing priorities with reduced staff resources.

Deliver all aspects of the new Offices remit as provided by Statutory Footing, including name change, rebranding and new website.
Following the scoping study carried out in 2019, a Departmental led review provided updated recommendations on work required to place the office on a Statutory Footing and this included the rebranding of the office. To date no further work has been completed on this aspect of the review. Work is also to commence on improving the level of information provided in the current website and its format.

Communicate to stakeholders and promote the new Office of Prison Ombudsman for Northern Ireland.
The development of a communication strategy to promote the new office and the proposed legislative changes remains outstanding, dependent on agreement for implementing Statutory Footing.

2. Complaints and Death in Custody Investigations

Despite best efforts it is disappointing to report that we were unable to reduce the backlog of complaints to an acceptable level as had been anticipated. Indeed the number of complaints outstanding increased to 393 at the year end, from a starting position of 281 complaints outstanding. The Office continued to be affected by vacancies and absenteeism the result of which was that of necessity Investigators had to take on additional administrative tasks. In turn this negatively impacted on the length of time taken to complete investigations. However, a new Senior Investigations Officer and 2 new Investigators were recruited which helped to alleviate some of the pressures experienced. Allocating responsibility for Disclosure for the Coroner to the Admin team also enabled Death in Custody Investigators to better focus on investigative practices.

Produce investigation reports that are evidence-based and impartial.
I acknowledge that opinions about report quality can often be subjective, especially if the evidence is inconclusive. However, where challenges are mounted, we commit to comprehensively reviewing the evidence gathered to ensure adherence to the Prison Rules and our own Terms of Reference. The "Lessons Learned" process to evaluate all investigations and reports produced, continues to provide a useful quality control mechanism.

Ensure full compliance with Complaints and Death in Custody Terms of Reference by Investigators.
Internal review and quality assurance of all complaints and Death in Custody reports produced indicated compliance with the Terms of Reference, especially the important principles of evidence based and impartial practice. Feedback was provided to Investigators both individually and collectively in order to maintain standards and support their professional development. As previously highlighted an updated Terms of Reference for Complaints issued on 01 August 2022 however the Terms of Reference for Deaths in Custody remains to be implemented.

Adhere to timescales in all investigations (9 months for draft Death in Custody reports and 18 weeks for final complaints reports).
The Death in Custody target was not achieved for any of 6 investigation reports completed throughout the year. Delivering investigations in line with the performance target to issue draft Death in Custody reports within 9 months remains challenging for a variety of reasons including: the ability to complete interviews, a lens on evidence that lacks focus on matters of concern for preventing future deaths in custody, the lack of timely responses to requests for information and commissioned clinical reviews, delays at the factual accuracy stage and training a new Senior Investigations Officer.

The Complaints target of clearing all complaints within 18-weeks was not achieved with only 57% of complaints finalised within this timeframe. The Complaints team experienced delays in obtaining information and was impacted by the requirement to train new staff, earlier vacancies and staff absence. A refocussing on targets will be required in the year ahead

Ensure an Investigator is on site within four hours of being notified about a Death in Custody
Out of hours on-call arrangements i.e. to have an on-site presence within 4 hours of being notified of a Death in Custody were adhered to.

Conduct a quarterly validation exercise within each prison of accepted recommendations in complaints reports.
Not achieved due to ongoing operational priorities and resourcing issues, particularly within the Admin team who carry responsibility for reviewing accepted recommendations.

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 other operational pressures and staff resourcing issues.

Maximise accessibility for everyone who has contact with our services. Ensure low user groups - such as female individuals in custody, young offenders, foreign national individuals in custody and visitors - have opportunities to understand the role of the Prisoner Ombudsman.
Not achieved. We were unable to deliver outreach efforts due operational pressures and staff resourcing issues.

3. Support for Prison Service Complaints Handling

Efforts continue to encourage informal local resolution through the provision of telephone advice.

4. Support for Prison Service & Trust 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. The purpose of the meetings held throughout the year was to discuss Death in Custody and complaint findings, address areas of concern and recognise progress.

Meet regularly with Trust senior managers to share feedback from Death in Custody investigations and other matters of mutual interest.
Achieved. The Prisoner Ombudsman and the Acting Director of Operations continued to meet with senior officials in the Trust throughout the year during which they took the opportunity to address issues of concern and promote opportunities for learning and improvement. Engagement with a new Strategic Programme and Performance Group (SPPG), a body that oversees the delivery of health and social care services in Northern Ireland took place for the first time during which it was agreed that regular meetings should be scheduled to ensure effective partnership working.

Contribute to the training of the Prison Service and Trust staff if requested.
The Prisoner Ombudsman regularly provided training to Prison Service recruits throughout the year.

5. Corporate Affairs

Prepare a 2020-2024 Strategic Plan.
Achieved. The 2020-2024 Strategic Plan issued in May 2021 and a copy is available **here**.

Monitor financial performance against the Contingency Planning Envelope allocation for Non-ringfenced Resource DEL of £810,000 and Capital DEL of £4,000 for 2022-2023.
Achieved. Regular monitoring and reporting to DOJ Financial Services Division and management of finances within allocated budget achieved with no overspend.

Publish Annual Report by September 2022.
Not achieved. Publication of this Annual Report by September 2022 was not possible due to competing operational priorities.

Issue two editions of 'Inside Issues' magazine to individuals in custody.
Not achieved. It is again disappointing to report that the Inside Issues magazine did not publish during 2022-2023. This was due to focusing on other competing priorities with reduced staff resources.

Complaints

Staff Complement

The issues surrounding staff resourcing and retention have been outlined earlier in this report. This undoubtedly hampered efforts to not only clear an already existing backlog of complaints investigations, but also to handle new and incoming complaints within expected timeframes.

Cessation of the Exceptional Assessment and Investigation Process (EAIP) and Improved Preliminary Investigation Processes

Last year's Annual Report provided information on the Exceptional Assessment and Investigation Process (EAIP) introduced during the Covid-19 pandemic to manage the backlog of Complaints investigations.

Whilst the introduction of the EAIP had some success it was a temporary measure, aimed at reducing the backlog. When the backlog reached manageable numbers the process came to a conclusion and learning was drawn from the experience to improve investigative practice. This included a Preliminary Investigation approach that would focus on more speedy investigation of low risk complaints. The Preliminary Investigation stage allows Investigators to focus on the following key aspects in order to identify complaints that can be cleared at an earlier stage:

- Withdrawn Complaints
- Early resolution
- Complaints falling under Prison Rule 79N
- Completing an Investigation within 30 days
- Issue based Complaints identified and looked at together
- Thematic Complaints identified and conducted as a single investigation
- Stop the Clock Complaints

Following legal advice the Ombudsman adopted an approach set out in Prison Rule 79N which had not previously been applied, This require extensive benchmarking work to ensure the application of the Rule was supported by a robust policy framework and clear documenting of decision-making to provide assurance to complainants through clear lines of sight on investigations. Investigators take a view on the complaint in relation to Prison Rule 79N, whether the complaint falls under this rule which allows for complaints that are vexatious, repetitive, frivolous, raise no substantial issue or that the complaint either on its own or taken together with other complaints was intended to seriously hamper the proper operation of the complaints procedure to be rejected for investigation. The application of Prison Rule 79N is a non-derogable power and there is, therefore, no scope for the Prisoner Ombudsman to delegate decision making powers in relation to the application of Rule 79N.

Since 01 August 2022 when the updated Complaints Terms of Reference became effective and the EAIP process ended, 26 complaints have been dealt with under Prison Rule 79N. Unfortunately, it proved necessary to put mitigations in place when a number of Rule 79N letters issued to complainants in advance of this date. In response to this significant error, processes were reviewed and training put in place to ensure this would not happen again.

A Thematic Approach to Complaints Investigations

On 27 February 2023, the Ombudsman, recognising the pressures being faced, exercised discretion to suspend the allocation of complaints in date order and introduce a more thematic approach to complaints investigations. Under Prison Rules there is a requirement to report on the outcome of investigations individually to complainants. The thematic approach allows for a single investigation to be carried out in circumstances where the same or similar complaints are raised by a number of different complainants. The thematic report issues to each individual complainant to fulfil standards set out in Prison Rules. This approach is not normative but provides another tool for investigators to address complaints in a timely manner. As this approach was only initiated towards the end of the current reporting period its success will be assessed in the next reporting period.

Prison Service Internal Complaints Process

The Prison Service operates an Internal Complaints Process (ICP) and an individual in custody's right to lodge a complaint to the Prison Service underpins this process. While anecdotal evidence suggests that individuals have mixed views about the effectiveness of the ICP, there appears to be no general reluctance to submit complaints. Our perspective is that an effective ICP is the first cog in a process designed to increase the confidence of individuals in custody in making a complaint about matters affecting them including their welfare and safety. When complaints are made to my Office, on completion of the Prison Service Internal Complaints Process, 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 1,520 (at 1 April 2022, compared with 1,374 at the same point the previous year) 7,722 complaints were made to the Prison Service during the reporting period, an increase from 6,704 (15%) the previous year. Prison Service data for the period April 2022 - March 2023 shows:

Of the 7,722 complaints made to the Prison Service;

- 5,880 (76%) were closed at Stage 1
- 1,064 (17%) were closed at Stage 2
- 365 (5%) were closed as rejected or upon the complainant's release
- 22 complaints were marked as 'open'.

Complaints can only be escalated to my Office when Stages 1 & 2 of the ICP have been completed, unless they are closed under Prison Rule 79B in which case an Ombudsman's investigation is required even when that complaint has been closed at Stage 1. At that point there are a number of other avenues for redress open to those in custody, including judicial review and monitoring mechanisms such as those provided by the Independent Monitoring Board.

Separated individuals in custody on Maghaberry Prison Roe House Landings 3 and 4 lodged 217 complaints in the reporting period, an increase of 79% compared to the previous 12 month period (121). One complaint was received from separated individuals in Bush House Landing 1 and 2.

394 (5%) of the overall complaints made to the Prison Service came to my Office during 2022-2023.

Complaints received by the Prisoner Ombudsman 2022-2023

Of the 394 complaints received, the majority came from Maghaberry Prison as shown in Column 4 of Table 1. Below:

Table 1. Number of individual complaints received during 2022-2023

Prison	Prison Population	% of total population	Individual complaints	% of all complaints
Maghaberry -Roe 3 & 4 Separated Individuals in Custody	30	2%	217	55%
Maghaberry- Bush House 1&2- Separated Individuals in Custody	15	<1%	1	<1%
***Maghaberry –others**	931	61%	103	26%
Magilligan	416	27%	61	15%
Hydebank Wood (young men)	59	4%	2	<1%
Hydebank Wood (female)	69	5%	8	2%
Visitors	N/A	N/A	2	<1%
Overall Total	**1,520**	**100%**	**394**	**100%**

Integrated Individuals in Custody (i.e. those in general prison population)

Overall there was a significant reduction in the level of complaints received from individuals in the general prison population across all prisons when compared to the complaints received in the previous 12 months 177 compared to 278 the previous year (36%). This represents just over 2% of all complaints initiated via the Prison Service internal complaints process (7,722).

The low number of complaints from young men and women in Hydebank Wood College and Women's Prison continues to remain a matter of concern, however, a number of factors must be taken into account when analysing these statistics not least the different types of prison environment and the specific needs of the individuals in custody in their respective care. As before, we will continue to monitor and consider how the Office ensures individuals in custody are aware of and understand how to make a complaint to my Office.

Separated Individuals in Custody (those who have met the criteria for separated status)

Separated individuals in custody held on Roe House 3 & 4 landings at Maghaberry Prison lodged 217 individual complaints in the report period, compared to 85 in the previous year (155% increase). One complaint from Bush House separated landings was escalated to my Office during the same period.

Although the number of separated individuals in custody represent approximately 2% of the total prison population, it is significant that overall, 55% of the complaints received were from individuals in this category.

Complaints handling April 2022 - March 2023

Table 2 sets out the numbers of complaints cleared by the Office during the period April 2017 - March 2023. The number of complaints cleared during the current year increased by 35 overall from 236 in the previous year to 271. Broken down, 124 cases were investigated, there were 3 complaints closed by way of local resolution and the number of cases released/withdrawn was 144[1].

1 Based on recent legal advice received outside of the reporting period, when an individual is released from custody, the investigation of their complaint continues regardless of their release.

Table 2: Complaints cleared April 2017 - March 2023

Year	Investigated & Reported	Local Resolution	Withdrawn/ Released	Total
2022-23	124 (46%)	3 (1%)	144 (53%)	**271**
2021-22	190 (80.5%)	18 (7.6%)	28 (11.9%)	**236**
2020-21	391 (86%)	6 (1%)	57 (13%)	**454**
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**

Table 3 provides a breakdown of outcomes for the complaints investigated and reported on by this Office and allows for comparison of between years.

Table 3: Outcomes for Complaints Investigated April 2017 - March 2023

Year	Upheld	Partially Upheld	Not Upheld	Total
2022-23	6 (6%)	N/A	118 (95%)	**124**
2021-22	37 (19.5%)	0 (0%)	153 (80.5%)	**190**
2020-21	23 (6%)	8 (2%)	360 (92%)	**391**
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**

My Office can identify some repetitive themes within complaints including for example:

- Issues about handling mail
- The impact of staffing challenges on, for example, purposeful activity
- The delivery of education
- Visiting Arrangements
- Telephone issues

There were 7 recommendations for improvement in response to complaints made by individuals in custody during the year and all 7 were accepted by the Prison Service.

Table 4 provides an analysis of the range and nature of complaints received from those in custody in Maghaberry Prison from where the majority of complaints arise.

Table 4: Maghaberry Integrated population Main Complaint Topics 2017-2023

Complaints Topic	2022-23	2021-22	2020-21	2019-20	2018-19	2017-18
Staff attitude	2	56	41	35	50	26
Accommodation	10	19	19	12	23	12
Property and Cash	14	36	19	18	15	24
Adjudications	2	2	1	5	15	5
Tuckshop	3	8	0	4	11	-
Complaint Procedure	3	16	17	4	9	-
Mail	3	10	13	2	8	7
Discrimination	2	6	4	2	8	2
Visits	6	4	8	5	7	7
Searching	0	4	2	4	7	2
Transfers/Allocation	5	9	6	1	6	6
Regime	2	6	7	2	6	6
Adverse reports	1	4	12	3	5	2
Food	2	3	0	2	5	-
Telephone	6	9	3	6	5	-
Lock down	4	2	0	0	4	1
Education	2	0	0	2	2	6
Health & Safety	4	1	5	3	1	3
Home leave	0	3	0	4	-	1
Miscellaneous	32	32	24	24	33	38
TOTAL	**103**	**230**	**181**	**138**	**209**	**148**

Complaint Case Studies

Mr A complained that the Prison Service did not respond immediately nor appropriately to an emergency situation related to his physical health after he had become unwell.

An investigation into the complaint took place with all relevant records obtained and policies reviewed. The individual was interviewed and media footage was viewed. My investigator assessed each of the individual issues raised by the complainant separately and established that in relation to the allegations there was evidence that the Prison Service had acted reasonably and fairly and, crucially, alerted Healthcare staff immediately to Mr A's deteriorating health.

On the basis of the information the complaint was **not upheld**.

Ms B about the difficulties being experienced maintaining telephone contact with loved ones during a family crisis due to faults on the telephone lines. They stated that this was having an impact on their mental health.

Faults included interference on the line, losing connections, long delays in obtaining connection and the inaccurate logging of faults.

The Investigating Officer reviewed the position in respect of telephone lines across the prison establishment, considered previous similar complaints and the action taken by the Prison Service in terms of having the faults addressed and also assistance with establishing contact with family members.

My Investigating Officer established that Compassionate Temporary Release had been granted in addition to increased virtual visits and also that the Prison Service had acted reasonably and immediately to report faults although the remedial action was outside their control.

The complaint was **not upheld**.

Mr C made an allegation of assault against members of Prison Service staff.

My Investigating Officer reviewed the available evidence including viewing media footage. There was no direct coverage of the incident.

From review of all the evidence my investigating Officer confirmed that Mr C had thrown an implement at Prison Officer necessitating intervention. The Prison Service appropriately gave Mr C the opportunity to seek medical assistance and lodge a claim of assault with the PSNI. Policy and procedure was followed by the Prison Service.

As the Prison Service administered their standards properly, the complaint was **not upheld.** One recommendation was made, namely, that Prison Officers in the relevant area were reminded of the benefits of activating their Body Worn Video Camera, especially in sudden situations which may escalate. This recommendation was accepted and a subsequent memo issued to Prison Officers in addition to an agenda item on staff briefings for Senior Officer's to raise by way of reminder.

Mr D made a complaint that he had not received his newspapers on time. He provided third hand evidence that the newspapers had been delivered to the prison by the supplier on the day in question.

Responding to Mr D's complaint, the Prison Service said they had not received the newspapers. My Investigating Officer confirmed with the supplier that the newspapers had been delivered and concluded it was highly likely that the newspapers went missing following delivery to the prison.

My Investigating Officer established that the Prison had failed to properly investigate the complaint.

The complaint was **upheld.** I recommended that the Prison Service consider reimbursing the cost of the newspapers as well as reminding staff of the need to exercise care when transporting, processing and recording receipt of such publications. The Prison Service accepted and implemented the recommendations.

Deaths in Custody

Prisoner Ombudsman investigations into deaths in custody assist the State to fulfil its duty, as required by Article 2 of the European Convention on Human Rights, by informing the Coroner's Inquest which is required by law. The PSNI further inform the Coroner's Inquest. The Prisoner Ombudsman is notified when a death occurs after which an investigator will attend the scene within 4 hours.

The specific aims of Death in Custody investigation are to:

- Establish the circumstances surrounding the death;
- Examine the care provided to the deceased by the Prison Service and Trust;
- Assess whether improvements could help prevent a similar death in the future;
- Ensure the bereaved family can raise concerns;
- Assist the Coroner's inquest.

During 2022-23, 13 notifications were received of which 6 were deaths in custody, 5 post release deaths and 2 serious adverse incidents (SAI). Arising from this, 12 investigations were initiated, 5 in Maghaberry Prison and 2 in Magilligan Prison. The 5 remaining investigations were Post Release Deaths in the community. A Serious Adverse Incident reported in Maghaberry Prison did not require investigation following further scrutiny of the circumstances.

The number of deaths notified this year has increased by 8 when compared to the previous year (3). The overall increase arises mainly due to increased reporting of post release deaths reported i.e. 5 post release deaths were notified this year compared to none the previous year. It is often the case that reporting of post release deaths is cyclical and dependent on media coverage – one report leading to another. This is an area in which there is a distinct lack of knowledge of the realities of what happens in the post release period. Additionally, 2 Serious Adverse Incidents were notified this year which is comparable with that reported in the previous year.

The Death in Custody team successfully completed 6 Death in Custody investigations during the reporting period. This was a significant achievement in light of a reduced staff complement. Reports were published for 5 Death in Custody investigations. A sixth report was not published after consultations with the Coroner. The published reports contained 18 recommendations for improvement, 11 for the Prison Service, and 7 for the Trust. Of the 18 recommendations 3 were joint recommendations for both the Prison Service and the Trust. Two out of the 3 joint recommendations were not accepted by Trust. All the recommendations were accepted by the Prison Service.

As at 31 March 2023, the Death in Custody team carried an outstanding caseload of 19 cases broken down as follows:

- 19 live investigations (13 deaths in custody, 4 post release deaths and 2 SAI); and
- 6 investigations were completed and the reports forwarded to the Coroner.

Opportunities for Interagency meetings remain in place. This arrangement is valuable in that it serves as a mechanism to achieve strategic, agreed recommendations for improvement.

Corporate Affairs

Finance & Accountability

The Prisoner Ombudsman's opening Contingency Planning Envelope for 2022-23 for Non-ringfenced Resource DEL was £810,000 and Capital DEL of £4,000. A final closing budget allocation for Non-ringfenced Resource DEL was £851,000 and Capital DEL of £4,000 was confirmed by the Department in December 2022. Of necessity, the focus during the year was to work within the Contingency Planning Envelope with little to no scope for discretionary spend. Two business cases were prepared during the reporting period. My Office complies with the Department of Finance's Managing Public Money NI guidance 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 Department.

This places particular emphasis on:

- The Prisoner Ombudsman's overall aims, objectives and targets in support of the Department'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 accounts for its performance.

As an Advisory NDPB the Office is funded from the DoJ Safer Communities Core Directorate budget rather than by grant-in-aid. As such, any expenditure incurred by the Office is recorded as part of DoJ departmental expenditure. This means the Office does not produce its own set of accounts nor lay its finances before the Assembly separately from the DoJ.

Quarterly overview meetings took place throughout the year with the Department as scheduled.

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 the Department of Finance Construction and Procurement Delivery (CPD) guidelines and approvals processes. The current contract for Media/PR Services expired on 31 March 2023 and work is ongoing to procure a new service provider.

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

Information Security

The Director of Operations manages Information Security, which aligns 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. All Staff receive appropriate training and are 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. The Senior Management Team reviews the Risk Register regularly and internal controls provide proportionate and reasonable assurance of effectiveness in line with identified risks. The Senior Management Team oversees the management of internal controls together with risk management and regularly reviews their effectiveness.

Shared Services

Corporate shared services include:

- NICSHR and NICSHR Connect services have provided Payroll and Human Resources support since April 2010;
- Finance transactional support functions have been provided via the Account NI shared service system since July 2012; and
- DOJ Financial Services Division provide retained finance functions.

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.