The Prisoner Ombudsman for Northern Ireland

PRISONER OMBUDSMAN FOR NORTHERN IRELAND

ANNUAL REPORT 2016-17

CONTENTS	Page

FOREWORD

I am pleased to present my fourth and final Annual Report, which covers the period April 2016-March 2017.

The role of the Prisoner Ombudsman is to investigate and report on deaths in custody and prisoners' complaints.

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

Three of the Maghaberry prisoners died in the month of November 2016. The chronological proximity generated understandable shock, especially as none of them was being managed under the procedures for prisoners who are considered to be at imminent risk, at the time of their deaths. 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 41 recommendations for improvement in death in custody (DiC) reports, of which 90% were accepted by the NIPS and the SEHSCT. We made a further 63 recommendations in a case of serious self-harm. Since the UK incidence of self-inflicted deaths in custody is 8.6 times higher than in the general population, it will remain very important for the NIPS and SEHSCT to continuously review progress in implementing recommendations for improvement which they accept from this office and other oversight bodies.

We received 4,299 complaints, a 25% increase on last year. Only 202 of these came from integrated prisoners and the others were multiple, identical complaints from separated prisoners on Roe 4 landing 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 and improvement in complaints-handling there during the reporting period.

We made 94 recommendations for improvement in relation to prisoners' complaints. At the time of writing 64% of these had been accepted by the NIPS.

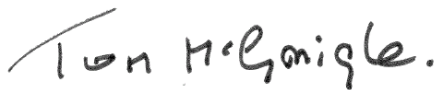
The process for placing this office on a statutory footing progressed through the Northern Ireland Assembly and the Justice (No 2) Bill received royal assent on 12th May 2016. It was therefore disappointing that underpinning Regulations could not be completed before dissolution of the Assembly on 26th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

There were significant changes of personnel and our investigative staff capacity was depleted by 40% during the second half of 2016. However by March 2017 the team was almost back to full strength.

I raised concerns 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 am due to retire from the role of Prisoner Ombudsman in August 2017. It is encouraging to report some positive developments since taking up post in June 2013, especially progress towards placing the office on a statutory footing. Prisoners' mental health issues now have a higher profile and professional relationships are good with all the relevant agencies. This office is well placed to fulfil its responsibilities and I hope progress can be maintained after the local political situation stabilises.

I would like to place on record my appreciation for the cooperation received from the NI Prison Service, the South Eastern Health & Social Care Trust, the Department of Justice and the Coroners Service, as well as for the levels of interest shown by politicians and the media throughout my tenure. I am especially grateful for the contribution of everyone in the Prisoner Ombudsman's Office and wish my successor well in delivering an important public service in the future.



Tom McGonigle
Prisoner Ombudsman for Northern Ireland

June 2017

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.

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 current (third) Prisoner Ombudsman - Tom McGonigle - was appointed by the Minister of Justice on 1st June 2013.

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 2017 the staff complement comprised 11 people:

- Prisoner Ombudsman (4 days per week)
- Director of Operations
- 2 x Senior Investigators
- 5 x Investigators; and
- 2 x Administrative Support staff.

There were significant staff changes during the year: the Director of Operations and Office Manager retired, a Senior Investigator transferred within the NICS, an Investigator was on leave for the majority of the year and another Investigator's secondment ended. While the DoJ maintained the office's core complement of Investigators and there was no loss to the

overall headcount, we had to manage substantial gaps between people leaving and their replacements - who required considerable induction - arriving.

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 2016-17, 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 2016-17 opening budget was £592,000, 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

We continued to work to the Corporate Plan for 2014-17 which was published in March 2014. It provides the organisation's strategic and operational framework. A Business Plan for 2017-18 was published in March 2017, setting out more precisely the annual objectives and resources to be employed to achieve them.

Management Commentary

Statistical Headlines for 2016-17

- **Investigations initiated into the deaths of 5 prisoners and 2 ex-prisoners**
- **8 investigations completed by the DiC team and 4 reports published**
- **41 recommendations for improvement in DiC reports/ 90% accepted**
- **4,299 complaints received, an increase of 25% from 2015-16**
- **84% of integrated prisoners' complaints came from Maghaberry**
- **38% of complaints were Upheld or Partially Upheld**
- **94 recommendations for improvement in complaint reports/ 64% accepted at time of writing**

Performance against targets 2016-17

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;

The Justice [No2] Bill received royal assent on May 12th 2016. Work on the Regulations commenced in June 2016 and was still ongoing at the end of the 2016-17 reporting period. The Ombudsman continued to engage regularly with DoJ officials and members of the Justice Committee. Terms of Reference cannot be updated until the Regulations are agreed.

Contribute to the Department of Justice Statutory Footing Working Group;

The Prisoner Ombudsman and Director of Operations were integrally involved in the work of the Statutory Footing Project Board.

Address the implications for current PO staff

The statutory footing process did not generate any tangible implications for existing staff during this reporting period.

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.

N/A as the statutory footing process was not completed during the reporting period.

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: SEHSCT delays in providing evidence, arranging staff interviews and factual accuracy feedback led to overruns in forwarding draft DiC reports to bereaved families. The matter is beyond our control but I must again express concern that delays have continued from last year, as they undermine the credibility of external oversight. Context is of course all-important, and the Trust explains that it has to prioritise patient services which can result in delays.

Most draft complaint reports were not sent for factual accuracy check within the target period. This was because the investigations that we commenced were part of a large backlog and were very short-staffed during the second half of 2016. It was also partly due to delays in receiving material, accessing witnesses for interviews and receiving feedback from the NIPS. The situation began to improve towards the end of 2016.

Deliver the recommendations of the independent review of our professional practice in investigating and reporting on Complaints that was published in November 2015.
We met with the NIPS during the year to address the implications of this review and achieved some progress against its recommendations. As a result NIPS turnaround times for factual accuracy checks improved.

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

Update Complaints and DiC Terms of Reference once the position is clear in respect of statutory footing.
N/A as the statutory footing process was not completed during the reporting period.

Agree dip-sampling process with the NIPS in respect of Hydebank Wood and Magilligan complaints that were finalised at internal NIPS Stages 1 & 2.
Partially achieved – A sample of complaints at Hydebank Wood and Ash House were examined in March 2017 and the findings were shared with the NIPS.

Apply mechanism agreed with the NIPS for monitoring implementation of accepted recommendations via a dip sample.
Partially achieved - as with other areas of work, monitoring of recommendations was manageable at Hydebank Wood and Magilligan, but problematic at Maghaberry where the volumes involved were considerable.

Assess implementation of accepted 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.
Partially achieved – The Criminal Justice Inspectorate provided useful feedback in relation to accepted DiC recommendations following their May 2016 inspection of Hydebank Wood and Ash House.

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 maintaining the bi-monthly "clinic" at Hydebank Wood for young male prisoners and contributing to foreign national prisoner's fora at Maghaberry. The numbers of formal complaints from low users did not increase but we identified several local concerns and ensured prison managers were made aware of them.

We regularly visited Ash House Women's prison and raised issues with governors that prisoners there reported to us informally.

We piloted clinics at Maghaberry Visitor Centre in agreement with the Centre manager during 2016, though discontinued the pilot because numbers of visitors using the Centre had declined substantially.

"Inside Issues" was prepared and circulated to every prisoner in July 2016 and January 2017.

3. Support for NIPS Complaints Handling

Assist the NIPS to improve local resolution of complaints. In 2016-17 this will include comparison against the baseline established during 2014-15.
The reduced number of complaints received by this office from integrated prisoners suggests this was partially achieved. However it was not measured, mainly because measurement was a low priority for the NIPS due to more pressing priorities at Maghaberry Prison.

Contribute to relevant consultation exercises, conferences and other events to share the findings of Complaint and DiC investigations.
The Prisoner Ombudsman gave evidence to the Assembly's Justice Committee and the Health Committee. He gave interviews to broadcast and print media about topics that included the 2015-16 annual report and other publications; and he contributed to the Ministerial Forum on Safer Custody.

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 continued 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 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 Ombudsman and Director of Operations contributed to several training events for NIPS new recruits, Senior Officers and middle managers, as well as providing training inputs for SEHSCT personnel who worked in prisons.

Engage with other government departments to support policy-making that assists prison reform.
The Ombudsman's evidence to the Health Committee and Justice Committee of the Northern Ireland Assembly contributed to raising the profile of mental health difficulties among the prison population.

5. Corporate Affairs

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 all levels plus forfeiture of ½ administrative post contributed to compromising the timeliness of investigations. However it was helpful that the DoJ agreed we should retain our investigative capacity at a time when other NI Civil Service departments lost staff.

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 2016.
Achieved - the 2015-16 Annual Report was published in June 2016.

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 2017 there were 1,434 people in the three prisons in Northern Ireland. NIPS data for April 2016 – March 2017 shows:

11,145 complaints were made to the NIPS, of which:

- 6,135 (55%) were closed at Stage 1
- 4,439 (40%) were closed at Stage 2
- 356 (3%) were closed upon the prisoner's release
- 214 (2%) were still open on 31st March 2017.

Separated Republican prisoners on Maghaberry's Roe 4 landing lodged 5,418 complaints, an increase of 18% on last year and almost half of all complaints. The number of complaints made to the NIPS by other prisoners (5,727) reduced significantly - by 13% - from last year (6,596). 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 2016-17 we continued our outreach efforts to ensure low user groups, such as foreign national prisoners and young men, were aware of our office and knew how to complain properly.

Table 1 – Complaints Received by Prisoner Ombudsman April 2016 – March 2017

Location	Total	Percentage of all complaints	Percentage of complaints excluding Roe 4	Percentage of overall prison population on 31 March 2017
Roe 4	4,097*	95%	-	2%
Maghaberry Others	169	4%	84%	59%
Magilligan	32	1%	16%	30%
Hydebank Wood	1	-	-	6%
Ash House	0	-	-	4%
Overall Total	4,299			

**This total includes 18 individual complaints*

Integrated Prisoners

202 complaints were escalated to our office by integrated prisoners, a decrease from 345 in 2015-16. This represents only 4% of all the complaints that prisoners initiated via the NIPS Internal Complaints Process. 91% of the complaints that were escalated to us were made by sentenced prisoners and only 9% by remand prisoners.

Table 1 illustrates that 84% (169/202) 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 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 a dip sample of complaints that were closed by the NIPS at Stages 1 & 2 of their Internal Complaints Process at Hydebank Wood and Ash House during 2016, in order to assess whether those complaints had been dealt with fairly and an adequate response provided to the complainant. 70% from a sample of 40 were deemed to have been dealt with appropriately, with evidence of a proper investigation and adequate response. The dip sample report contained four recommendations for improvement.

Roe 4

Separated Republican prisoners held on Roe 4 landing at Maghaberry Prison increased the volumes of multiple identical complaints that they lodged; and they routinely refused to accept NIPS responses at Stages 1 and 2. During 2016-17 they comprised less than 2% of the total prison population, but made 95% of the complaints that were received by our office. Many related to procedural matters, but the prisoners' main concerns still involved controlled movement, full body searching and refusal of permission for a small number of other prisoners to join them on Roe 4.

4,097 complaints that were received by this office during 2016-17 came from prisoners on Roe 4. It was agreed with the prisoners and with the NIPS that we would group these complaints on a thematic basis in order to reduce investigative and administrative pressures.

We investigated and reported on Roe 4 prisoners' complaints in the same way as all other complaints, in line with the Prison Rules and Terms of Reference, and our duties of impartiality and independence. 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 2017.

Table 2 – Complaints cleared April 2013 – March 2017

	Investigated & Reported	Local Resolution	Withdrawn/ Released	Total
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 308 complaints were cleared by this office during 2016-17 (Table 2). The increase in "Withdrawn/Released" complaints was due to complainants being released before their investigation was completed.

Table 3 provides a breakdown of outcomes for the complaints that were investigated and reported on by this office. The reduction in upheld complaints appears due to improved complaints handling by the NIPS at Maghaberry.

Table 3 – Outcomes for Complaints Investigated April 2013 – March 2017

	Upheld	Partially Upheld	Not Upheld	Total
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 destabilizing effect on prisoners who have limited opportunities for contact with their families and few personal possessions.

We made a total of 94 recommendations for improvement in response to prisoners' complaints during 2016-17. At the time of writing 64% of these had been accepted, 16% rejected, and 20% were awaiting a decision from the NIPS.

Table 4 – Maghaberry Integrated Prisoners Main Complaint Topics 2016-17

Complaints Topic	2016-17	2015-16	2014-15	2013-14	2012-13
Property and Cash	16	32	35	48	43
Visits	5	15	10	46	24
Staff attitude	33	61	35	46	36
Accommodation	11	51	43	41	7
Adjudications	7	6	6	15	4
Mail	4	9	3	21	7
Searching	1	6	13	21	9
Transfers	7	9	12	19	17
Health & Safety	1	12	0	18	6
Access to regime	7	7	4	15	19
Home leave	-	-	7	15	15
Lock down	7	13	12	14	22
Discrimination	4	7	3	13	16
Education	6	31	9	12	5
Adverse reports	2	3	5	10	4
Miscellaneous	58	152	79	96	163
TOTAL	169	314	276	450	407

Figure 1 - Eligible Complaints Received from integrated prisoners 2005-2017

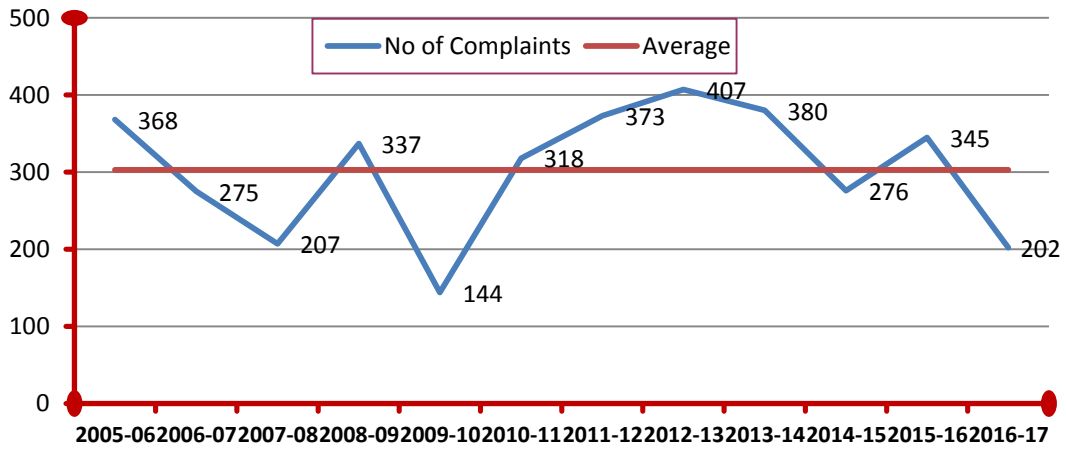


Figure 1 indicates that complaint trends have been very erratic over the years. This data needs to be treated with caution as different recording methods were used in the past: earlier figures may include complaints that were counted twice by being received in one year and concluded in the following year; the distinction between "Eligible" and "Ineligible"

complaints was not always clear; and Healthcare complaints were removed from the Prisoner Ombudsman's remit in 2008.[1]

[1] The Prisoner Ombudsman however still investigates the Healthcare dimension of Deaths in Custody.

Ordering clothes to Magilligan

Mr A complained about not being able to order clothes to Magilligan from the M&M catalogue.

Magilligan's response suggested he could have a clothes parcel sent in. However Mr A did not have anyone who could send him a clothes parcel; and the Stage 2 response did not indicate any further attempt to deal with his complaint.

We found the NIPS previously operated a system for prisoners to order clothes from the M&M catalogue, but M&M changed their system to on-line catalogues and ordering in October 2015. Maghaberry Prison had reviewed their ordering system in early 2016 as a result of the change and allowed prisoners to access the on-line catalogue and order clothing. However Magilligan had not reviewed its system by Autumn 2016, but said they hoped to do so in early 2017.

We upheld Mr A's complaint on the basis that the M&M catalogue had not been available for a year and a new process should have been implemented sooner, especially for prisoners like him who were unable to receive clothing from visitors. We recommended the NIPS should meet with Mr A to discuss his clothing needs; and if he had urgent requirements that could not wait, then a temporary means of enabling him to order essential items should be put in place.

Missing Property

Mr B complained about missing property - new clothing - which had been handed into Maghaberry reception in December 2015. It had been signed for by Reception staff but subsequently gone missing. Mr B complained at the time and submitted a claim form. However his claim was also lost and the fact that he was later transferred to Magilligan, and subsequently to a prison in England, made it more difficult to pursue the matter.

We traced the original receipt of goods in Maghaberry and recommended that Mr B should submit a new claim to the NIPS. While there were no purchase receipts to verify the clothes' value, in **November 2016 the NIPS offered Mr B an ex-gratia payment** pending production of further receipts or information. The offer is currently with Mr B for consideration.

Back Injury

Mr C asked us to consider a complaint that his back was injured during a full body search. He also stated that he had not been helped to get up off the floor and dress after the search had been completed.

CCTV footage indicated that Mr C offered passive resistance and there was no significant use of force by prison staff. There was no specific point at which he appeared to receive an injury or began to feel pain.

When the search was completed, two nurses completed Injury Report forms. They recorded that he reported lower back pain after the search, was offered pain relief and stated he could get up off the floor. This was corroborated by audio recording.
Mr C was later examined by a nurse, a GP and a physiotherapist for lower back pain. The outcomes included a routine referral to the physiotherapist. However he did not attend subsequent physiotherapy appointments and was therefore discharged.

We did not uphold Mr C's complaint but recommended the NIPS should review their policy in respect of full body searches and consider making provision in that policy for assisting prisoners who are having difficulty in clothing themselves after a full body search has been carried out.

Lost Money

Mr D asked my office to investigate his complaint about a large sum of money which he claimed to have lost while on a working-out scheme. He could not account for it and wanted to find out who had been with him in his room on a day when he thought the money had gone missing.

He had initially raised the matter as a request to the NIPS. However he did not receive a reply for over two months, and because of this delay he proceeded to lodge a complaint. The NIPS responses pointed out the following factors:

- He was unable to function at the most basic level on the day in question because he had consumed a quantity of psychoactive substance and collapsed;
- No CCTV footage was available because Mr D delayed by seven months in lodging his request. At best therefore their investigation depended on the personal recall of staff long after the event;
- He had been given a lockable safe cash box and had a bank account opened for the express purpose of keeping his money safe.

Mr D acknowledged he had taken drugs and had refused to go to hospital on the date in question. Police confirmed that he never reported a theft of money, and therefore no PSNI investigation took place.

We did not uphold this complaint. However we recommended the NIPS should respond promptly to prisoners' requests, both in order to address the substance of the matter and also in order to head off unnecessary complaints that may subsequently arise.

Written Warning

Mr E asked us to investigate a complaint about a warning on his adjudication record. He said he had received the warning for failing to comply with a request to help clean his house. He set out reasons why he believed this warning should not have been issued: he had been given a week off work to recuperate as he was coming off a SPAR; and also that, as a remand prisoner he was not obliged to work.

The NIPS response stated he should have made clear to staff any medical reason for not agreeing to assist with the cleaning task.

A copy of the written warning confirmed Mr E had refused to assist orderlies to clean the house. However it also stated that he refused to return to his cell when instructed, which was *"not the behaviour expected of an Enhanced prisoner."* Nothing in the SPAR documentation indicated that he should refrain from work.

The written warning was therefore issued for two reasons - refusal to assist with cleaning and refusal to return to cell when instructed. It represented a minor outcome which would only apply for six weeks, and would not be referred to in any further disciplinary procedures. This seemed a reasonable response and **we did not uphold this complaint.**

Gamblers Anonymous in Magilligan Prison

Mr F complained about the absence of gambling rehabilitation services at Magilligan prison. Gamblers Anonymous (GA) had withdrawn their services from Magilligan due to a funding shortage. While Mr F was released from prison before the investigation was completed, he wanted it to continue.

GA's funding problem was beyond the NIPS control. However Mr F's sentence was linked to a gambling issue, with which he and others had previously received assistance. **We partially upheld his complaint** and recommended the NIPS should pursue all available options to address gambling addictions, including Freephone counselling and GA appointments during resettlement leave.

The NIPS accepted our recommendation and in August 2016 began a pilot scheme for prisoners to enrol on a monthly contact class with GA, with the option of follow-up appointments to be arranged directly with GA.

Deaths in Custody

We initiated investigations into five deaths in custody and two 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 five deaths in custody. One involved a prisoner at Magilligan and four involved Maghaberry prisoners. There were no deaths at Hydebank Wood or Ash House. Three deaths appeared to be self-inflicted, and the causes of two were unclear at the time of writing. Definite causes of death in all cases are only determined at the Coroner's inquest.

Three of the Maghaberry prisoners died in the month of November 2016. The chronological proximity of their deaths generated understandable shock, especially as none of them was being managed under the procedures for prisoners who are considered to be at imminent risk, at the time of their deaths. 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.

Each post-release death was subject to a preliminary investigation to establish whether there was any link to the person's time in custody. Post-mortem results and toxicology tests to date have not shown any such link. Rather in each of these deaths it was apparent that the prisoners had been well-prepared for release, but had subsequently been unable to sustain abstinence in respect of pre-existing drug and alcohol problems.

We completed eight investigations - into three deaths in custody, one serious self-harm incident and four post-release deaths; and we published four reports.

The published DiC reports contained 41 recommendations for improvement (11 for the NIPS, 25 for the SEHSCT and five joint recommendations), of which 90% (37) were accepted.

We made 63 recommendations in the case of serious self-harm. It was disappointing that 15 of these had been made previously by this office and accepted by the NIPS and SEHSCT.

We concluded there were no matters that required further investigation in respect of the four post-release deaths. However 10 recommendations for improvement were made in two of these cases.

On 31st March 2017 there were five DiC investigations ongoing.

Comparisons

The Ministry of Justice's "Safety in Custody Statistics Bulletin to December 2016" stated *"2016 has seen a record level of 354 deaths in prison custody, up 97 from the previous year. Three of these were homicides, down from 8. There was a record high of 119 self-inflicted deaths, up 29…. The rate of self-inflicted deaths has doubled since 2012. The likelihood of death in*

custody is 1.7 times higher than in the general population, while self-inflicted death is 8.6 times more likely."

The Scottish Prison Service's "Deaths in Prison Custody Report 2016" revealed that in 2016 there were 28 deaths in their establishments; and there were 34 deaths in custody in the Republic of Ireland from 2012-2014.[2]

Dublin Institute of Technology: "*2015 Deaths in Custody; Is Ireland's Investigative Process Compliant with Article 2 of the European Convention on Human Rights?*"

Corporate Affairs

External Communication

Publication of each DiC report and the 2015-16 Annual Report were accompanied by a press release and where appropriate, supplementary communications activity.

The Ombudsman gave evidence to the Justice Committee of the Northern Ireland Assembly in October 2016 and to the Health Committee in November.

He maintained contact with relevant bodies during the year. These included the Coroner's Service, the Parole Commissioners, the Regulation & Quality Improvement Authority, the Northern Ireland Assembly Ombudsman, Criminal Justice Inspectorate, International Committee of the Red Cross, British-Irish Intergovernmental Secretariat, Prison Review Team Oversight Group members and HM Inspectorate of Prisons.

He contributed to the Ministerial Forum on Safer Custody; and met with visitors including the Chief Executive Officer of the UK Equality and Human Rights Commission, the Chair of the UK National Preventive Mechanism and the Republic of Ireland's Ombudsman who was expecting to establish a prisoner's complaint system in his jurisdiction.

He met local political representatives in relation to prison issues and the statutory footing process; and held a monthly stocktake with the NIPS Director-General and a quarterly stocktake with the governor of each prison.

The Prisoner Ombudsman was a regular visitor to the prisons, where he met prisoners individually and collectively. He also met with prisoners' families.

"Inside Issues," a four page news sheet, was the Prisoner Ombudsman's main vehicle for communicating with prisoners. It included case studies, statistics and information about the complaints process in eight languages. Summer and Winter 2016 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 2016-17 was £592,000. 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 2016-17 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 2016-17.

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 HRConnect 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.

www.niprisonerombudsman.gov.uk
The Prisoner Ombudsman for NI
Unit 2, Walled Garden
Stormont Estate
Belfast, BT4 3SH