The
Prisoner
Ombudsman
for Northern Ireland

ANNUAL REPORT

April 2012 - March 2013

The Prisoner Ombudsman for Northern Ireland

FOREWORD

BY THE PRISONER OMBUDSMAN

As I complete my final term of office as Prisoner Ombudsman on 31 May 2013, my reflection of the past 12 months takes place within a wider view of the last five years. It has been a busy and eventful time since I was appointed in September 2008 and much has been achieved.

This year, the Office of the Prisoner Ombudsman completed 344 complaints investigations, published six death in custody reports and undertook our first 'near death' investigation. This has all been delivered for an operating budget of £712k and reflects a consistently high level of individual and team productivity.

Five years on, the operation of the Office is now one of much greater efficiency, effectiveness and accessibility. Prisoners can contact the Office through a dedicated Freephone system operating across the prison estate (with a link to a translation service for callers who do not speak English) and our staff can immediately advise whether a complaint is eligible. Our systems have been overhauled to support improved investigation methodologies, thorough quality assurance procedures and the generation of comprehensive business management information. The Office has also fully embraced a more outward facing role through enhancing our family liaison efforts and by proactively engaging with stakeholders, influencers and decision makers. Our commitment to openness and transparency has also been supported by the publication of all death in custody reports and by participating in a

wide range of conference, education and training events. Together these changes have not only supported our continuous development and improvement, but have also helped to build confidence in our independence and in the integrity of our investigations.

It is fair to say that we see both very constructive and very unhelpful examples of internal complaint handling within the Prison Service.

An indication of the growth in confidence in our operation and service has been the increasing prisoner contacts and the rise of complaint numbers over the years. Whilst this trust in our service is to be welcomed, it is regularly the case that complaints we receive could, or should, have been resolved internally. Although the Office of the Prisoner Ombudsman was established to help to ease tensions in prison and to provide an appropriate way for prisoners to deal with difficulties, complaints can only be referred to the Prisoner Ombudsman once the Prison Service Internal Complaints Process has been exhausted. It is in everyone's best interest that the Prison Service is able to effectively deal with prisoner complaints internally, as far as possible. To this end, the Office never permits prisoners to bypass the Internal Complaint Process and I meet regularly with prison governors to discuss and support their efforts to make the Internal Complaints Process more effective. It is fair to say that we see both very constructive and very unhelpful examples of internal complaint handling within the Prison Service.

Nevertheless, when our investigatory role is required, we make strenuous efforts to ensure that our investigations are relentlessly objective and impartial and that any recommendations are realistic, achievable and produce constructive improvements. Crucially, the Office has also maintained primacy in healthcare aspects of death in custody investigations. This has ensured that a holistic approach to all death in custody investigations has been successfully developed to deliver investigative integrity to a more reliable standard than has been achievable in other jurisdictions. Over 86 per cent of Prisoner Ombudsman recommendations are now fully accepted and a recent example of the impact they can have is the root and branch reform of the arrangements for distributing prisoner medication.

Over 86 per cent of Prisoner Ombudsman recommendations are now fully accepted.

In our work, we also see evidence of much good practice within the Prison Service and South Eastern Health and Social Care Trust and we take great care to recognise this where we find it. It is vital moving forward that good staff doing their very best to provide an effective and caring service are not punished for honest mistakes. There is a real risk that fear of making mistakes can lead to a 'tick box' approach that undermines the ability of prison staff to apply common sense and compassion to prisoner care.

Prison reform is now underway and there is widespread recognition of, and commitment to, the need for change. I am proud of the role that the Office has played in developing awareness of the need for reform, particularly through our reporting of deaths in custody which, by their public nature, have often added impetus to acknowledging and addressing the issues of concern identified. However, the pace of prison reform must gather greater momentum to see the progress to date yield positive results.

The Owers Review did not result in the production of a 'Patten style' implementation plan and has not enjoyed the resourcing and financial investment that supported policing reform in Northern Ireland – not least because of the underpinning objective to substantially reduce the cost of the Prison Service. In this context it is to note that whilst the cost per prisoner in Northern Ireland has reduced to £75,000, this is eye watering compared to a private prison I visited in the North of England that places rehabilitation and reducing reoffending at the heart of its operations at a cost of £19,000 per prisoner annually. I am convinced that we can learn from the private sector in terms of achieving greater creativity and quality of service, while a focus on the bottom line drives efficiency and effectiveness. Certainly, it is my view that a fully focused and results based approach to prison reform in Northern Ireland can be benefited from taking lessons from such examples.

The absence of a coherent joined up plan with key activities properly sequenced has limited the progress made to date on delivering the programme of change and the return on money that has been invested in kick starting reform. Nevertheless, a financial plan is

2012/2013 at a glance:

344 complaint investigations

6 death in custody reports published

1 'near death' investigation

now being produced, severance and recruitment programmes are well under way and new rationalised structures, staff profiles and shift patterns are being implemented. Additionally, a change team with responsibility for producing a forward plan is now doing its work. Some progress has also been made towards cultural change and the emphasis of the new staff training programme is one of positive engagement and problem solving. The new Director General is very determined to modernise the service and significant efforts have been made by governors, at Maghaberry in particular, to develop more positive regimes locally. This will help to maximise the return on the efforts of the many existing staff who are very committed to rehabilitating offenders. Whilst these are positive developments, the full impact has yet to be realised and prisoner lockdowns continue to be a problem in many areas. There is still much improvement to be made and a number of factors are significantly impacting upon the quality of regime offered to prisoners. Crucially, there are far too many prisoners with not enough to do and the progress of the work required under the prison reform programme to deliver adequate and consistent purposeful, rehabilitative activity for prisoners is well behind what is required. This includes the provision of education and skills training; work experience; behavioural change programmes; exercise and leisure activities and a wide range of other activities and interventions that can help to motivate prisoners to change offending behaviour and prepare for release. This is particularly important given the challenging health and social characteristics of the prison population. For example, more than 70 per cent of prisoners are unemployed at the time of committal and more than 70 per cent of prisoners suffer from two or more mental disorders. Similar statistics relating to poor literacy and numeracy levels, low qualification attainment, being taken into care as children, substance misuse, and so on, tell much the same story.

There is still much improvement to be made and a number of factors are significantly impacting upon the quality of regime offered to prisoners.

Operational shortfalls within the current prison system are also exacerbated by the fact that the 1800 plus prison population continues to increase, with the percentage of remand prisoners in Northern Ireland's prisons more than double that in England, Wales and Scotland. The problem is particularly acute in Maghaberry where up to 55 per cent of prisoners are on remand at any one time. It is therefore extremely welcome that the Justice Minister intends to introduce the 'Faster, Fairer Justice Bill' into the Assembly this summer in order to address delays in the justice system and provide alternative arrangements to deal with fine defaulters.

My hope as I conclude my role as Prisoner Ombudsman is that the prison reform programme will continue to be implemented with zealous determination and dedication by everyone who has a role to play. The commitment of the Justice Minister has been particularly encouraging and I am also confident that the role played by the Office of the Prisoner Ombudsman can continue to go from strength to strength.

A year ago, I announced that the Justice Minister had confirmed that arrangements would be rolled out to place the Office of the Prisoner Ombudsman on a statutory footing. I am therefore pleased to note that the Department's work is almost complete

in preparing a draft consultation paper with a view to submitting these proposals to the Justice Committee in the coming weeks and to engage in public consultation over the summer. A number of potential legislative vehicles have also been identified. Given the job we do in carrying out substantial serious incident and death in custody investigations and assisting the State in delivering its human rights obligations, I cannot emphasise enough the need to progress this issue urgently. Despite the wishes of colleagues to be helpful, the absence of statutory footing unavoidably affects the Office's working relationship with the Coroner, the PSNI and the South Eastern Health and Social Care Trust, all of whom have legal duties and responsibilities related to information sharing. As a result, the Office been forced to dedicate considerable time and money (in legal costs) into trying to work around all of these difficulties and to rely extensively on personal relationships to overcome obstacles and concerns, particularly in connection with the accessing of critical information. This is not acceptable.

It is truly testament to the extraordinary efforts and commitment of my staff that so much has been achieved by the Office over the past five years. I am so proud of our team and grateful for their dedication, loyalty and resolve to go the extra mile, particularly during times when the Office was forced to cope with resourcing difficulties. They are great ambassadors for the Prisoner Ombudsman's Office and it has been a real privilege to work with them.

It has been a particular pleasure to contribute to the training of the new recruits to the Prison Service.

I am also appreciative for the co-operation and support from the staff at a range of agencies, including the Northern Ireland Prison Service; the South Eastern Health and Social Care Trust; the Criminal Justice Inspection Northern Ireland; the Regulation and Quality Improvement Authority; the Probation Board for Northern Ireland; the Independent Monitoring Board and the Police Ombudsman for Northern Ireland, as well as many of the equivalent agencies in Great Britain and Ireland. Special mention should go to Brian Grzymek from our sponsor body, who relentlessly does his best to support our work. I am also very grateful to all of the often unsung heroes and heroines, my colleagues in the voluntary sector, who quietly touch the lives of so many prisoners. I have, at times, felt completely humbled watching them in action and thank them for the chance to work with them and benefit from their enthusiasm and dedication. Likewise, I have been moved by the families I have had to meet within the worst of circumstances when their loved one has died in custody. My hopes for future change in the Prison Service are as much for them as for those prisoners who are currently held within Northern Ireland's prisons. Finding out how their child, parent or sibling died in custody can be a truly traumatic experience and yet many have often remarked on the need for the story to be told so that other families do not have to suffer the same despair as they have.

A significant part of my role has also involved contributing to numerous events and conferences in order to educate wider audiences about the role of the Office. It has been a particular pleasure to contribute to the training of the new recruits to the Prison Service. They bring a wonderful array of skills, experience and talent which, if properly harnessed, can contribute so much to the development of a purposeful and rehabilitative prison regime. I have also met many times with the Prison Change Team and the Prison Reform Oversight Group, as well as the Justice Minister and his senior officials, the Committee for Justice, and members of the Committee for Health, Social Services and Public Safety. I have also engaged with political parties more generally throughout my time as Prisoner Ombudsman and I am grateful for the widespread political interest in, and support for, the work of the Office.

It has been an honour to have held the position of Prisoner Ombudsman for five years and I wish the incoming post holder every success in undertaking this important and rewarding role.

Pauline McCabe
Prisoner Ombudsman for Northern Ireland
May 2013

OUR MISSION AND OBJECTIVES

Our Mission

To help ensure that prisons are safe, purposeful places through the provision of independent, impartial and professional investigation of complaints and deaths in custody.

OBJECTIVE ONE: **INDEPENDENT**
To further develop and maintain prisoner confidence in the independent and objective approach of the Office of the Prisoner Ombudsman.

OBJECTIVE TWO: **PROFESSIONAL**
To continuously review and develop the investigation processes for complaint and death in custody investigations, ensuring high standards of investigative practice, robustness and a proportionate approach.

OBJECTIVE THREE: **EFFICIENT**
To ensure that the Office is efficient and compliant with relevant legislative and governance requirements.

OBJECTIVE FOUR: **SERVICE**
To provide an effective and courteous service to all stakeholders and to positively influence the implementation of recommendations that improve the delivery of a purposeful, rehabilitative regime.

OBJECTIVE FIVE: **COMMUNICATION**
To maximise awareness of the role of the Prisoner Ombudsman amongst key stakeholders in a changing environment; 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.

OBJECTIVE SIX: **DEVELOPING ROLE OF THE OFFICE**
To secure statutory footing and to further develop the role of the Office to meet emerging needs and future opportunities.

Prisoner Ombudsman Costs 2012/2013

	£k
Staffing Costs	550
Accommodation Costs	57
Professional Advice[1]	61
Other running costs[2]	44
Operating Total	**712**
Exceptional costs[3]	32
Grand Total	**744**

[1] Professional advice includes legal advice, clinical reviews, other specialist reviews and reports, design and PR support.
[2] Running costs cover a range of activities including printing of documents, stationery, staff travel costs, training.
[3] These are one off costs associated with our office relocation.

DEATH IN CUSTODY INVESTIGATIONS

Overview

Since 1st September 2005, the Prisoner Ombudsman has been responsible for death in custody investigations and also has the discretion to investigate the deaths of former prisoners, where the circumstances of the death may relate to the care received in prison.

There have been 43 deaths in Northern Ireland prisons since September 2005. 42 of these prisoners were male and one was female.*

Of these deaths, 27 were in Maghaberry Prison, 12 in Magilligan Prison, and 4 in Hydebank Wood Prison and Young Offenders Centre.*

Investigating deaths in custody

The aims of death in custody investigations are to:

- Establish the circumstances of the death;
- Examine whether any change in operational methods, policy and practice, or management arrangements would help prevent recurrence of a similar death or serious event;
- Inform the Coroner's inquest; and
- Address any concerns of the bereaved family.

As part of death in custody investigations, independent and appropriately qualified experts are engaged, where necessary, to carry out a full clinical review of the healthcare provided to a prisoner whilst in prison.

In order to maximise the effectiveness of investigations in a timely manner, it is the Prisoner Ombudsman's practice to inform the Prison Service and South Eastern Health and Social Care Trust of serious areas of concern as and when these are identified.

* Figures correct at May 2013.

Remit of Investigations

The South Eastern Health and Social Care Trust assumed responsibility for the delivery of healthcare within prisons in October 2008. Whilst the Commissioner for Complaints investigates prisoner complaints about healthcare, the Prisoner Ombudsman retains overall responsibility for investigating healthcare aspects of deaths in custody. Matters concerning the application of Prison Service policy and practice, staffing and healthcare issues are inter-related and this arrangement ensures a comprehensive approach and full consideration of all relevant evidence. The Prisoner Ombudsman has no responsibility for investigating the care of a prisoner whilst in an outside hospital.

Working with Bereaved Families

The death of a loved one in prison can be particularly difficult because of the limited information a family has about the last hours and days of the prisoner and the exact circumstances of the death.

The Prisoner Ombudsman is committed to working closely with families in a way that is fully open and transparent but also sensitive to, and respectful of, their needs.

The purpose of this family liaison is to:

- Meet at an early stage to discuss family concerns and questions;
- Keep families up to date on emerging findings and progress;
- Ensure that investigation reports address family concerns and questions;
- Give the family an opportunity to discuss the draft investigation report; and
- Agree appropriate arrangements for the publication of reports.

Working with Key Stakeholders

The need to keep the Prison Service and South Eastern Health and Social Care Trust fully informed of serious emerging issues is taken very seriously. There is also ongoing liaison with the Prison Service, the Trust and Criminal Justice Inspection Northern Ireland (CJI) to report the progress of investigations. The Prisoner Ombudsman also meets the Regulation and Quality Improvement Agency (RQIA) to discuss healthcare issues and meets CJI inspectors before prison inspections. Where appropriate, the Ombudsman contributes to thematic reviews in the justice sector.

Deaths in Custody 2012/13

Six death in custody reports were published this year (Apr 2012 - Mar 2013).

This included investigations into the deaths in custody of Patrick Duffy *(published 13 June 2012)* and Aaron Wayne Hogg *(published 28 June 2012)* - as detailed in the Prisoner Ombudsman 2011/2012 Annual Report published in July 2012.

Investigations were also completed into the deaths in custody of:

William Devine *(Died: 26 August 2012)*
- Report published: 29 June 2012
- Cause: advanced cancer
- No issues of concern identified

Frank Laffin *(Died: 26 August 2012)*
- Report published: 2 November 2012
- Cause: terminal illness
- No issues of concern identified

Samuel Carson *(Died: 4 May 2011)*
- Report published: 20 November 2012
- Cause: death by suicide
- 28 issues of concern identified

Frances McKeown *(Died: 4 May 2011)*
- Report published: 28 November 2012
- Cause: death by suicide
- 18 issues of concern identified

There are currently eight ongoing death in custody investigations. One further investigation into the death of Joseph Abraham has been completed and will be published on 22 May 2013.

Key issues

During the course of death in custody investigations, the Prisoner Ombudsman has found evidence of efforts made by the Northern Ireland Prison Service and South Eastern Health and Social Care Trust to deliver a caring and compassionate service, particularly in the case of prisoners suffering with terminal or chronic illnesses. However, many areas of concern have also been identified.

The significant issues arising from the death in custody investigation reports completed in 2012/2013 include:

- Failure to implement the Prison Service's anti-bullying policy and appropriately investigate alleged bullying incidents;
- Inadequate consideration of the need for/slow progress in actioning mental health referrals;
- Failure to request/examine community and prison healthcare records;
- Inappropriate risk assessment for, and supervision of, prescribed medication;
- Inadequate care planning and care coordination for vulnerable prisoners;
- The availability of illicit substances;
- Insufficient time out of cell/lack of human contact for vulnerable prisoners;
- Extended periods of lock down, particularly during holiday periods.

Near Death Investigation

The Prisoner Ombudsman recently completed the Office's first 'near death' investigation as a result of an attempted death by suicide at Maghaberry Prison.

Following a direction from the House of Lords in connection with the need for independent investigation in the case of near fatal incidents, the Prison Service determined in January 2010 that the Prisoner Ombudsman should be asked to investigate serious incidents in circumstances *"that without immediate intervention the prisoner would have died; that as a result of the incident the prisoner has suffered a permanent or long term serious injury; and that as a consequence of the long term injury sustained, the individual's ability to know, investigate, assess and/or take action in relation to the circumstances of the incident has been significantly affected".*

The near death of 'Mr C', reported by the Prisoner Ombudsman in May 2013, highlighted 44 issues of concern, including:

- Gaps in prison and healthcare staff knowledge in relation to appropriate implementation of SPAR and mental health referral protocols;
- The inadequate consideration given to the appropriateness of extended cellular confinement for a vulnerable prisoner;
- Concerns about the arrangements for medically assessing prisoner fitness for adjudication/cellular confinement;
- Failure to implement the Prison Service's bullying policy and appropriately investigate or consider alleged threats to prisoner safety;
- Inadequate care planning arrangements.

The investigation emphasised the importance of near death investigations in highlighting issues of concern and providing learning and service improvement opportunities for both the Prison Service and the South Eastern Health and Social Care Trust. The Prisoner Ombudsman has always considered the Prison Service's current criteria for triggering a near death investigation as unduly restrictive and believes that any serious incident resulting in permanent physical and/or mental impairment should warrant investigation by the Prisoner Ombudsman. The Director General of the Prison Service has now given a commitment to review this.

Implementation of recommendations

The final report by the Prison Review Team, chaired by Dame Anne Owers and published in October 2011, delivered a comprehensive, up to date picture of the entire custodial system which reconciles many issues that have been identified time and again through various reports from the Office of the Prisoner Ombudsman, amongst others.

In February 2011, in her interim report, Dame Owers said:

An early task for the change management team will be to rationalise and prioritise the outstanding recommendations from the various external reviews and monitoring bodies. They have become a barrier rather than a stimulus to progress, with a plethora of action plans at local and central level, and a focus on servicing the plans rather than acting on them. This has led to inspection and monitoring being defined as a problem within the service, rather than a solution and a driver for change.

The Prison Service and South Eastern Health and Social Care Trust are currently engaged in two programmes of work with the aim of achieving significant change in Northern Ireland prisons by 2015.

In light of Dame Owers' comments and in order to support the development of a more strategic and joined up approach to service development, the Prisoner Ombudsman took a decision in June 2011 not to make recommendations following death in custody investigations and instead to detail issues of concern that the Prison Service and South Eastern Health and Social Care Trust are expected to fully address, with appropriate urgency, in the context of their programmes for change. This approach remains under review and the Prisoner Ombudsman will revert to making recommendations if not satisfied that the response of the Prison Service and/or Trust is appropriate.
To date, the response to areas of concern identified in Prisoner Ombudsman death and near death in custody investigations demonstrates that the issues identified, many of which are very challenging, are being given a high level of priority by the Prison Service and the Trust in the context of the change programmes. Recent examples of this include a fundamental review of medicine prescribing and supervision arrangements in prison and the development of new arrangements for more effectively coordinating the care of vulnerable prisoners by Prison Service and Trust staff. It is vital moving forward that these and other developments in response to evidenced issues of concern are consistently applied to a high standard.

COMPLAINTS INVESTIGATIONS

Overview

The Prisoner Ombudsman investigates complaints submitted by individual prisoners, ex-prisoners and prison visitors who have been unable to resolve their problem through the Prison Service's Internal Complaints Process.

- 407 eligible complaints were received in 2012/2013.
- A total of 344 complaint investigations were completed in 2012/2013, including 54 complaints carried forward from 2011/2012.
- 117 complaint investigations remain ongoing at year-end.

The Complaints Process

Wherever possible, complaints brought by prisoners, ex-prisoners or visitors to prison establishments should be resolved internally through the Northern Ireland Prison Service's own, two stage, Internal Complaints Process. For a complaint to be eligible for investigation by the Prisoner Ombudsman, it must first have been through both stages of the Internal Complaints Process. If the complainant is not satisfied with the response received from the Prison Service during this process, the complaint can then be escalated to the Ombudsman for investigation.

Prisoners can register complaints in writing using a printed form available in each prison, or by using a Freephone service from telephones located throughout Northern Ireland prisons. Over recent years, the Freephone service has become the most popular method of registering complaints with the Office and almost 80% of complaints were registered using the service in the last twelve months. Foreign national prisoners can register their complaint through an interpreter, if required. The interpretation

service links the prisoner with the Prisoner Ombudsman's Office and an interpreter in a three way conversation, thus ensuring that the prisoner is able to register the complaint and receive the correct advice directly from the Office.

Figure 1 shows that there were 789 prisoner contacts with the Office and of those, 407 were registered as an eligible complaint. This represents an increase of around 10% on the same period last year.

The number of ineligible complaints received by the Office continues to reduce and now forms 28% of the overall total, compared to 34% in 2011/12 and as much as 50%-60% in prior years. Advice calls have also fallen by 39% in the past 12 months. These significant reductions appear to reflect both an increased awareness amongst prisoners that a complaint must first complete the two stage Internal Complaints Process before becoming eligible for consideration by the Prisoner Ombudsman and improving prisoner confidence in the operation of the Internal Complaints Process. It is however apparent, both through our contact with prisoners and the overall increase in eligible complaints year on year, that a significant opportunity to resolve more complaints internally still exists.

Figure 1. Prisoner Complaints

[1] Included 93 complaints from a single prisoner.

Origin of Complaints Received

The breakdown of complaints by prison shows a broadly similar pattern to previous years:

74%
of the complaints received in 2012/2013 were from Maghaberry prisoners who represent 56% of the total prison population.

16%
of complaints were received from Magilligan prisoners who represent 30% of the total prisoner population.

10%
of complaints were received from prisoners at Hydebank Wood. Hydebank Wood Female (Ash House) and Young Offenders Centre each accounted for 5% of the complaints received. The two establishments represent 4% and 10% of the total prisoner population respectively.

It is to note that the year on year reduction in complaints received from female prisoners in Ash House appears consistent with their repeatedly made claims that lodging complaints will adversely impact upon their regime and result in negative staff attitudes.

The Prison Service has been reluctant to acknowledge these concerns over the years and, moving forward, as more and more emphasis is placed on the delivery of a positive and rehabilitative regime, this will be an important issue for the newly appointed management team at Hydebank Wood both in Ash House and in the Young Offenders Centre.

Issues Raised in Complaints Received

The issues raised in complaints received this year cover a wide range of topics and vary significantly in terms of complexity. Figure 3 shows a detailed breakdown of the issues and concerns raised within complaints received this year, which are broadly similar to previous years.

Common complaint themes include:

- Issues related to staff attitude and behaviour;
- Problems with systems for managing prisoner property and cash;
- Cancelled visits or reduced visiting times;
- Association entitlement and regime availability including education, work and training;
- Long periods of lock down and confinement to cell;
- Problems relating to the operation of the tuck shop and prohibited items.

Figure 2. Complaints Received by Prison

	12/13	11/12
Total Complaints Received (Eligible and Ineligible)	567	573
Maghaberry	417 (74%)	401 (70%)
Magilligan	94 (16%)	110 (19%)
Hydebank Wood Female	28 (5%)	51 (9%)
Hydebank Wood and Young Offenders Centre	28 (5%)	11 (2%)

Problems resulting from the availability and deployment of staff have, this year, contributed to a wide range of prisoner complaints relating to lock downs, regimes and visits. In practice, these issues significantly relate to the management of a scenario where: a total of 287 staff have left the Prison Service through the Voluntary Early Retirement Scheme; there have been high staff absence levels; new shift arrangements have affected the uptake of overtime working; and there have been problems in embedding new industrial relations arrangements.

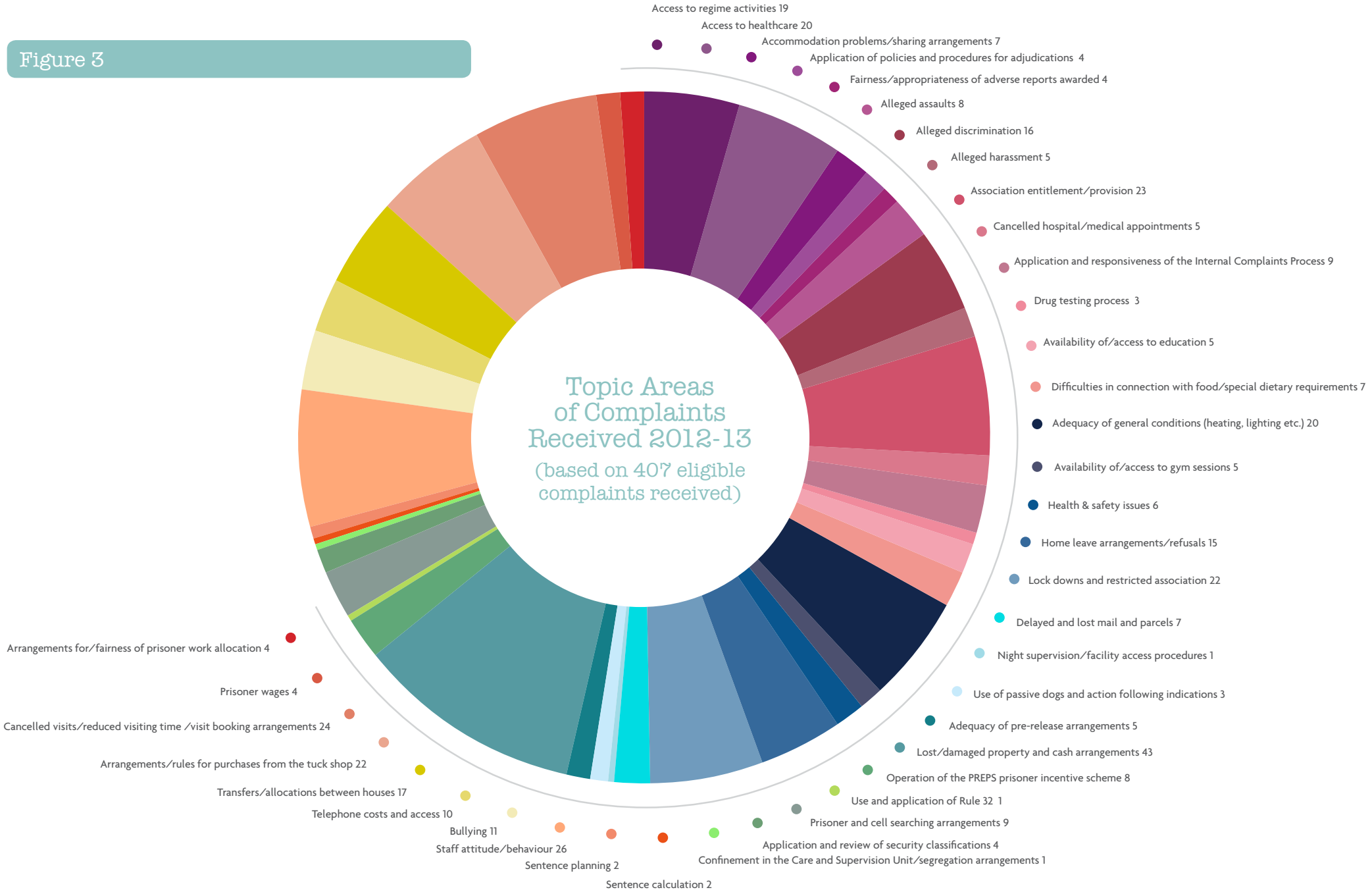
These difficulties and the pressure created upon prison resources, particularly at a time of increased prisoner numbers, have an adverse impact on:

- The length and frequency of lockdowns and association restrictions;
- The delivery of purposeful regimes, including adequate and meaningful education, rehabilitative programmes and vocational training;
- The availability of exercise and leisure activities; and
- The delivery of services supporting highly valued family contact, including visits and the delivery of mail and parcels.

It is, however, important to recognise that the Prison Reform Programme is now underway and there are many positive developments. In particular, 139 new custody officers have now completed their training and been deployed to permanent posts, while a further 39 new recruits commenced training in January 2013. New staff profiles and shift patterns are being implemented and local initiatives, particularly at Maghaberry, have resulted in more flexible staff deployment and less restrictions on the movement of lower risk prisoners.

The Change Team is also now actively progressing several important pieces of work with the aim of delivering a comprehensive, needs driven package of purposeful, rehabilitative activity and resettlement services for all prisoners. It is very much hoped and expected that these work programmes and initiatives will progressively address current challenges.

Figure 3


Topic Areas of Complaints Received 2012-13
(based on 407 eligible complaints received)
Access to regime activities 19
Access to healthcare 20
Accommodation problems/sharing arrangements 7
Application of policies and procedures for adjudications 4
Fairness/appropriateness of adverse reports awarded 4
Alleged assaults 8
Alleged discrimination 16
Alleged harassment 5
Association entitlement/provision 23
Cancelled hospital/medical appointments 5
Application and responsiveness of the Internal Complaints Process 9
Drug testing process 3
Availability of/access to education 5
Difficulties in connection with food/special dietary requirements 7
Adequacy of general conditions (heating, lighting etc.) 20
Availability of/access to gym sessions 5
Health & safety issues 6
Home leave arrangements/refusals 15
Lock downs and restricted association 22
Delayed and lost mail and parcels 7
Night supervision/facility access procedures 1
Use of passive dogs and action following indications 3
Adequacy of pre-release arrangements 5
Lost/damaged property and cash arrangements 43
Operation of the PREPS prisoner incentive scheme 8
Use and application of Rule 32 1
Prisoner and cell searching arrangements 9
Application and review of security classifications 4
Confinement in the Care and Supervision Unit/segregation arrangements 1
Sentence calculation 2
Sentence planning 2
Staff attitude/behaviour 26
Bullying 11
Telephone costs and access 10
Transfers/allocations between houses 17
Arrangements/rules for purchases from the tuck shop 22
Cancelled visits/reduced visiting time /visit booking arrangements 24
Prisoner wages 4
Arrangements for/fairness of prisoner work allocation 4

Time Taken to Investigate Complaints

The Prisoner Ombudsman's Terms of Reference require that complaints investigations are completed and a final report sent to the prisoner within 18 weeks of the complaint being received. Overall, 79% of investigations resulted in a response issued to the prisoner within 18 weeks or less. It is accepted, however, that in many instances this is too long and the Office continues to make every effort to achieve shorter reporting times wherever possible. Many complaints are therefore reported much sooner with 61% completed in 14 weeks or less.

Figure 4 details the time taken to issue complaint reports to both the Prison Service (for a factual accuracy check) and the complainant. It is to note that investigations of a serious or very complex nature are accounted for separately. In the first instance, some serious complaints may have to be referred to the PSNI for a criminal investigation.

Figure 4. Investigation of complaints 2012/2013

(a) Time to Northern Ireland Prison Service for factual accuracy check

Time	**Number of Complaints (Cumulative %)**
Up to and including 4 weeks	15 (8%)
5 to 8 weeks	28 (22%)
9 to 10 weeks	33 (39%)
11 to 12 weeks	36 (57%)
13 to 14 weeks	20 (66%)
15 to 18 weeks	38 (85%)
Over 18 weeks	30 (100%)
Net Total	200
Other	
Serious/complex investigations	29
Complaints not requiring factual accuracy check	106
Complaints withdrawn following commencement of investigation	9
Total Complaints Investigated	344

Figure 4. Investigation of complaints 2012/2013

(b) Time to complainant

Time	Number of Complaints (Cumulative %)
Up to and including 4 weeks	23 (10%)
5 to 8 weeks	44 (26%)
9 to 10 weeks	40 (41%)
11 to 12 weeks	30 (52%)
13 to 14 weeks	25 (61%)
15 to 18 weeks	48 (79%)
Over 18 weeks	57 (100%)
Net Total	267
Other	
Serious/complex investigations	29
Complaints investigated - not issued to prisoner*	8
Complaints awaiting factual accuracy by Prison Service	9
Total Complaints Investigated	344

* For example, if a prisoner has been released and left no forwarding address.

Recommendations Made and Implemented

251 recommendations
were made by the Office of the Prisoner Ombudsman to the Northern Ireland Prison Service during 2012/2013.

189 recommendations
- or 86% - of the 219 recommendations responded to at the time of this Annual Report's publication, have been accepted by the Northern Ireland Prison Service. 68 of those 189 recommendations (36%) have been confirmed as fully implemented by year end.

32 recommendations
have responses pending at year end.

COMPLAINTS CASE STUDIES

Visitor Parcels

During the summer of 2012, the Prisoner Ombudsman received complaints from several prisoners relating to visitors being prohibited from leaving clothing, newspapers or parcels at Maghaberry prison.

The Prison Service responded to each of the prisoner complaints explaining that staff shortages had resulted in the Parcels Intake Post not being staffed and visitors being unable to leave permitted items for prisoners. It was acknowledged by the Prison Service that the situation was "not acceptable" however, given the extent of the problems experienced, a number of prisoners were unhappy with the responses received through the Prison Service Internal Complaints Process and referred their complaints to the Prisoner Ombudsman.

It is Prison Service policy that property can only be left for prisoners at the time of visits. The facility to leave parcels can mean a great deal to prisoner families and to the prisoners who look forward to receiving them. The investigation found that, between 1 April 2012 and 31 July 2012, the Parcels Intake Post was closed or unable to accept clothing parcels during 37 visiting times. Neither prisoners nor visitors received prior notice of these restrictions, although for a time the policy on property was waivered to allow property to be left in at other times. In August 2012, parcel distribution delays of up to four days also occurred due to the breakdown of the delivery vehicle.

The Prisoner Ombudsman observed that, following a similar complaint in 2011, the Prison Service had accepted a recommendation to "ensure that a high level of priority is given to ensuring the full staffing of Visitors' Reception" where the Prisoner Intake Post is located. It was also noted that, following another recent Prisoner Ombudsman Investigation into similar issues, the Governor had issued a notice instructing staff that the Parcel Intake Post should, in future, not be routinely closed, save for very exceptional circumstances.

In light of this instruction, the Prisoner Ombudsman made no recommendation.

Opening Bank Accounts

Mr A complained to the Prisoner Ombudsman about being unable to open a bank account despite nearing the £500 maximum limit of his prisoner personal cash account. With two years remaining of his prison term, Mr A wished to begin saving money in preparation for his release and resettlement.

The Prison Service advised Mr A that prisoners must be in the pre-release stage of their sentence (generally 10-12 weeks before the earliest date of release) to be eligible to apply for a bank account. Mr A was further advised that applications for banking facilities were, in any case, currently suspended due to conditions imposed by the Financial Services Agency (FSA). Mr A was dissatisfied with the response he received through the Prison Service Internal Complaint Process and referred the matter to the Prisoner Ombudsman.

The Prisoner Ombudsman established that, in the months prior to Mr A's original complaint to the Prison Service, the facility for prisoners to open a bank account had been suspended by the sole bank providing the service as, under FSA guidelines, an applicant must attend a branch of the bank in person before any application can be processed. The Prisoner Ombudsman found that the Prison Service, the Consumer Council and the bank were engaged in trying to resolve the issue, but that the present situation was that no bank accounts could be opened for any prisoner. Whilst recognising the limitations imposed by FSA guidelines, the Prisoner Ombudsman recommended that the Prison Service continue their efforts to have a banking facility prisoners reinstated and/or replaced via other financial institutions. In support of these efforts, the Prisoner Ombudsman also wrote to the Consumer Council and other partners pointing out the relevance of the issue to effective resettlement and supporting the efforts being made to find a solution. The Prisoner Ombudsman also observed that the cost of resettlement (such as, securing accommodation, purchasing a vehicle, paying for training courses and education) is, generally, in excess of the £500 prisoner personal cash account limit. It was therefore recommended that, if banking facilities remained suspended, the Prison Service should explore internal alternatives for permitting prisoners to save additional earnings in a way that is not open to abuse. In the event that banking facilities were reinstated, the Prisoner Ombudsman also recommended extending the time before release that a prisoner is eligible to open a bank account. The Prison Service accepted three of four recommendations made but the recommendation in respect of increasing the £500 limit of prisoner personal cash accounts was not accepted. The Prison Service is now monitoring a pilot scheme currently operating in England for the management of prisoner bank accounts through a major financial institution. Subject to an outcome evaluation, it is hoped a similar pilot can be developed in Northern Ireland.

Lost Property

Mr B complained that he had not received a clothing parcel that had been brought to the prison by a visitor. He wished to be refunded for the items totalling £120.00.

The Prison Service informed Mr B that there was no record of any clothing parcels for him from a visitor at the time he had stated.

Mr B was not satisfied with the response of the Prison Service and referred his complaint to the Prisoner Ombudsman.

The Prisoner Ombudsman investigation found that although there was no record of property being received on the date in question for Mr B, there was a parcel in lost property containing the items described by Mr B which had been labelled and recorded under the prison identification number of another prisoner (who had already been released) with the same surname as Mr B.

It was not difficult for the Prisoner Ombudsman investigator, with the assistance of one member of prison staff, to check the appropriate property records, identify Mr B's missing property and deliver it to the reception of Mr B's landing.

Given the ease with which Mr B's property was found, the Prisoner Ombudsman pointed out that had the Prison Service been more diligent in its search for the missing property there would have been no need for the complaint to be escalated to the Prisoner Ombudsman.

Juvenile Regime Provision

Mr C, a juvenile prisoner, complained about the failure of the Prison Service to provide an adequate regime and constructive activity at Hydebank Wood Young Offenders Centre. Mr C was unable to attend education, work or the gymnasium, due to being restricted to his landing 24 hours a day.

The Prison Service response to Mr C's complaint stated that the purpose of the restricted regime was for his own protection and that of other juveniles on the landing, in order to minimise potential exposure to, and abuse of, illicit drugs known to be in circulation amongst juvenile prisoners and other inmates.

Mr C was not satisfied with the responses of the Prison Service and referred his complaint to the Prisoner Ombudsman.

The Prisoner Ombudsman's investigation found that Mr C was considered vulnerable as he was known to have misused drugs in the past. The restricted regime appeared, however, to have failed in its objective and Mr C was facing adjudication for failing a drug test and refusing to participate in subsequent drugs tests. As a result of his restricted regime, Mr C spent long periods of time in isolation, particularly when he became the sole prisoner on his landing following the release of other juvenile prisoners. This was doing nothing to address his desire to access illicit substances.

The Prisoner Ombudsman recommended that immediate arrangements be made for all juvenile prisoners to engage in an appropriate regime of purposeful activity. The Ombudsman also recommended that appropriate action be taken to directly address any deficiencies in managing the addiction problems of juvenile prisoners and that more effective action be taken to address the availability of drugs.

The Prison Service agreed to implement all of the recommendations. It is to note that from November 2012, prisoners under the age of 18 are no longer detained at Hydebank Wood Young Offenders Centre and are now accommodated at the Woodlands Juvenile Justice Centre in Bangor. The Prison Service does however reserve the right to detain juvenile prisoners at Hydebank in 'exceptional' circumstances. While no such circumstances have arisen to date, the Prison Service has accepted the need to provide an appropriate regime, should this situation arise in the future.

Tuck Shop Purchases

Mr D complained that an order he placed for a music CD from the tuck shop was refused due to inappropriate content.

The Prison Service observed that the album artwork of the CD in question depicted a masked gunman and a written reference to events which could be interpreted as supporting or glorifying violence. Mr D was advised that such content was not appropriate in the promotion of a neutral environment. Mr D was not satisfied with the response of the Prison Service and referred his complaint to the Prisoner Ombudsman.

The Prisoner Ombudsman established that decisions on the suitability of tuck shop items are made on a case by case basis and prison guidelines aim to balance an individual's freedom of expression under the European Convention of Human Rights with maintaining a neutral and respectful environment within prisons for prisoners and staff. In this context, 'items (pictorial or written reference) showing forms of weaponry, paramilitary slogans, badges or paraphernalia and/or activities that are clearly prohibited, or which could be interpreted as supporting or glorifying violence, (that might give offence to another prisoner or member of staff) are deemed to be unauthorised items'.

The Ombudsman concluded that it was reasonable that Mr D's request for the CD in question was denied and recommended that guidance should be issued to prisoners with regard to the rules governing tuck shop purchases.

The Prison Service is currently in the process of finalising a Standard Operating Procedure relating to symbols and associated matters. In light of this, the Prisoner Ombudsman's recommendation remains under consideration.

Escorted Release

Mr E complained to the Prisoner Ombudsman about his treatment as a 'category D' prisoner and alleged that security arrangements for escorting him to hospital appointments were not proportionate.

Mr E said that the escorted release security arrangement policy for his hospital visits, which states that all prisoners being transported must be handcuffed and escorted by at least two officers, is not appropriate to his individual risk as a 'category D' prisoner 'who can be reasonably trusted in open conditions'. Mr E also complained that the unavailability of escort staff had led to a hospital appointment to be cancelled at short notice.

Responding to these complaints, the Prison Service apologised for the cancellation of the hospital appointment and advised Mr E that he could not be permitted to attend hospital appointments alone until he had reached his pre-release home leave eligibility date and been fully risk assessed. This risk assessment, the Prison Service said, would be based on the prisoner's performance during home leave and that an unaccompanied hospital visit would not be permitted to a prisoner who was not currently registered on the home leave system.

Mr E was not satisfied with the responses of the Prison Service and referred his complaint to the Prisoner Ombudsman.

As stated, a Category D prisoner can be reasonably trusted in open conditions. The Prisoner Ombudsman noted that, under prison policy, the absence of a period of home leave does not preclude a prisoner from being considered for temporary release to access healthcare. The Ombudsman also observed that the correct application of the policy, and a cost effective approach, is in fact based on individual risk assessment. It was therefore recommended that the Prison Service review the current application of this policy to enable appropriately risk assessed prisoners, including those not registered on the home leave system, to attend medical appointments unaccompanied or with reduced security, as appropriate.

The Prisoner Ombudsman also recommended that the Prison Service consider whether it may be appropriate to replace the current mandatory use of handcuffs when escorting prisoners to hospital, with an approach based on an individual risk assessment and other relevant factors specific to the particular appointment. This recommendation is in line with a judgment of a previous Judicial Review in Northern Ireland which emphasised the need for proportionality when considering the use of handcuffs during hospital visits.

During the time Mr E's complaint was being investigated by the Prisoner Ombudsman, the Prison Service accepted, in principle, the need to review the current policy on handcuffing prisoners being escorted to outside hospital. However, a completion date for this review has not yet been established.

Religious Artefacts

Mr F complained that the Prison Service had failed to return religious incense and artefacts which had been removed from his cell when he had moved landings.

Mr F received numerous responses from the Prison Service which indicated that he would have his religious artefacts returned to him but this was not actioned. Mr F was not therefore satisfied with the response of the Prison Service and referred his complaint to the Prisoner Ombudsman.

The Prisoner Ombudsman investigation established that Mr F's items had been in fact been misplaced by the Prison Service and arrangements were subsequently made to replace the items. The Prisoner Ombudsman concluded that it was entirely inappropriate that the religious items were removed from Mr F in the first instance and this had been a clear breach of Prison Service policy.

The Prisoner Ombudsman therefore recommended that the Prison Service reissue guidance to staff in relation the provision of incense and artefacts for religious practice and carry out a training needs analysis in connection with respectful cell search procedures.

The Prison Service accepted both of these recommendations.

Full Body Searching

Mr G complained to the Prisoner Ombudsman about the frequency of full body searching he received compared to other prisoners. He believed that this was because of his religion.

The Prison Service advised Mr G that appropriate procedures in relation to full body searching had been followed. Mr G was not satisfied with the response of the Prison Service and referred his complaint to the Prisoner Ombudsman.

Under Prison Service rules, staff have a legal authority and duty of care to carry out searches of prisoners for a variety of different reasons. The Prisoner Ombudsman is fully committed to addressing the issue of the supply of drugs in prison and recognises the need for searching. The Ombudsman has also recognised that full body searching is an uncomfortable and demeaning experience for some prisoners and staff and fully supports efforts being made by the Prison Service to make the process as least intrusive and respectful as possible. In June 2010, the Prison Service introduced an arrangement for the prisoner record computer information system (known as PRISM), to randomly generate, on a daily basis, the prisoners to be full body searched by visits staff that day. Up to that time, prison staff had selected prisoners to be searched. The Prisoner Ombudsman investigation found that, on five occasions, Mr G was full body searched when he had not been randomly nominated by PRISM. It was established that this had resulted from system design issues and inaccurate recording of information. It was evident therefore that such failures were resulting in a inability to ensure that searching was genuinely random and not open to abuse. The Prisoner Ombudsman made four recommendations to address record keeping deficiencies, staff training needs, random search auditing procedures and arrangements for prisoners to see their name on randomly generated search lists. These recommendations were all accepted. A further recommendation that no prisoner should be able to avoid being nominated for a search for a significantly extended period was rejected because of concerns that it would interfere with the principle of 'randomness' and could be subject to abuse.

Female Temporary Release Policy

Ms A complained to the Prisoner Ombudsman about the Prison Service's refusal to permit her temporary release to attend her son's Confirmation. Ms A felt that she had been treated less favourably than other inmates making similar requests to attend important events involving their children, because of her religion.

The Prison Service advised Ms A that her request had been refused as she had not yet met the eligibility criteria required for temporary home leave. Ms A was not satisfied that the Prison Service's responses to her complaint adequately explained her treatment and referred her complaint to the Prisoner Ombudsman.

The Prisoner Ombudsman's investigation found evidence that Prison Service policy covering attendance at such events had, at times, been applied more flexibly in dealing with requests from other prisoners than in the case of Ms A. This was, however, found to be the result of differing management attitudes and approaches. The Prison Service accepted this finding and confirmed that decisions had, at times, been made that were not strictly policy compliant.

As a result of the investigation the Ombudsman made a number of recommendations. This included a recommendation that the Prison Service review the application of the 'Rule 27' provisions for temporary release in order to ensure that adequate consideration is taken of the specific needs of mothers in custody, in light of the importance of maintaining mother/child relationships and a mother's input into important family events and decisions. In making this recommendation, the Ombudsman recognised that female prisoners are more likely to be primary carers and, as such, this can make the prison experience significantly different for women and therefore places greater importance on the need to maintain the mother/child links.

The Prison Service accepted the Prisoner Ombudsman's recommendations and work is currently underway at Prison Service Headquarters to review the policy of the 'Rule 27' provisions for temporary release. The Prison Service has now confirmed that the new policy will take into account the "specific needs of women, many of whom are doing their best to care for their children whilst in custody".

The Prisoner Ombudsman for Northern Ireland

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