The Prisoner Ombudsman for Northern Ireland

ANNUAL REPORT

April 2010 - March 2011

FOREWORD BY THE PRISONER OMBUDSMAN

Following the Hillsborough Agreement, the past year has seen a number of important reviews taking place. The Office of Prisoner Ombudsman has made a significant contribution to this work.

I am very pleased to report that over the last three years, the backlog of 11 death in custody investigations outstanding when I took up the post of Prisoner Ombudsman in September 2008 has been cleared. A further 12 death in custody investigations have also been completed. Six are ongoing.

This is testimony to the dedication and hard work of my staff and represents important progress from the point of view of the families of those who have died in Northern Ireland's prisons.

In addition, the findings of death in custody investigations are informing efforts by the Prison Service and the South Eastern Health & Social Care Trust, which is responsible for healthcare in prisons, to improve and modernise the prison system.

As you will read in this report, the past year has seen a surge in the number of complaints made to the Prisoner Ombudsman. On the one hand, this demonstrates increased confidence in the fair and objective approach of the Prisoner Ombudsman's Office and reflects our efforts to ensure that we are fully independent in the regrettable absence of statutory footing. This increase in complaints also, however, highlights the very many respects in which the current regime in our prisons is in need of reform.

I believe our approach to resolving complaints in a fair and open way makes an important contribution to influencing the outlook of prisoners and encouraging more positive attitudes. Also, where we find that there is no foundation for upholding a complaint, we have found that explaining the grounds for such a finding is sometimes sufficient to dispel a prisoner's resentment at perceived unfairness.

Wherever appropriate, we ensure that recommendations we make are not only constructive but fit in and support Prison Service efforts to move forward.

Over 90 per cent of recommendations made following the investigation of complaints have been accepted for implementation by the Prison Service, again underlining the role that the Prisoner Ombudsman is playing in improving the prison environment. But it also indicates a level of responsiveness and recognition of the need for change that must now be harnessed to bring the proposals of the Prison Review Team, led by Dame Anne Owers, to fruition.

Long periods of lockdowns do nothing to address offending behaviour and are the enemy of the vulnerable.

It is also the case that the issues that give rise to complaints highlight the extent to which the Prison Service remains affected by its historical legacy.

At the same time, complaints point to shortcomings in human resources policies, working practices and agreements with the Prison Officer's Association (POA), which make it impossible to deploy staff in an efficient way.

The difficulties this can cause are particularly highlighted by the number of complaints from prisoners about unscheduled lockdowns and being kept in their cells for unreasonable lengths of time.

Long periods of lockdowns do nothing to address offending behaviour and are the enemy of the vulnerable.

It is evident from our investigations that there needs to be an appropriate, proportionate and dynamic response to security needs that goes hand-in-hand with a comprehensive reform of the existing work agreements, staff deployment arrangements and shift patterns, that make the Prison Service so inflexible and expensive. Staff must embrace their role in rehabilitating prisoners and encouraging individual offender responsibility as the route to preventing re-offending.

Many prisoners are also frustrated about the way the Progressive Regimes and Earned Priviliges Scheme (PREPS) for incentivising good behaviour is administered, believing that they have been denied association time they have earned. Having such a scheme and administering it badly is counter-productive. An effective incentive scheme, requiring prisoners to address their offending behaviour, should be at the heart of rehabilitation.

Addressing the legacy of the past also calls for a reassessment of what we as a society want to achieve through custodial sentencing. Of course prison needs to act as a deterrent to anyone contemplating crime and the most significant punitive effect of being sent to prison is the loss of freedom and the deprivation of contact with family and friends. However, it is also vital that there is a focus on rehabilitation.

Over and above the supervision and housing of prisoners, the key role of a modern Prison Service should be to work with prisoners to prevent re-offending. The prevention of re-offending must be at the heart of a victim-centred approach.

There is abundant evidence that promoting a more positive regime will reduce re-offending: in other words this is the route to making prison work.

97%...

...of offenders expressed a desire to stop offending

When asked which factors would be important in stopping them from re-offending in the future, the majority gave importance primarily to 'having a job'

68%

and 'having a place to live'

60%

Prison Reform Trust: Bromley Briefings Prison Factfile - December 2010

This means having purposeful regimes where individual concerns of prisoners are addressed by mentors and providing access to education, training, work experience and job search.

Promoting a more positive regime also requires the prison system to work in concert with providers of these and other services. Above all, there must be an environment which is modelled on how respectful, civil, law-abiding citizens behave and treat each other.

It is important to emphasise that the Prisoner Ombudsman is an independent, impartial and constructive arm of the criminal justice system. It is neither an arbitration service between the Prison Service and inmates, nor is it an advocate for inmates. Our investigations not only draw attention to bad practice, they highlight good practice too.

As Prisoner Ombudsman I have undertaken various outreach activities and attended conferences and seminars to share and discuss these insights and to encourage the public to think about what kind of justice system they want in the future. I believe there is a growing public awareness of the need for reform and an understanding that preventing re-offending is the best way to protect victims of crime and make our society safer.

The Office of Prisoner Ombudsman is committed to playing its part in the implementation of these much-needed reforms and in getting the Prison Service from where it is now to where it needs to be for the future.

Northern Ireland took on the responsibility for running its own criminal justice system over a year ago - just as tightening public finances prompted a need to cut public spending. As a result, the position of this Office and other agencies, public bodies and commissioners, not just within criminal justice but across Government, is under review.

I have no doubt there is scope to make the system as a whole more efficient, but a similar review in England concluded that the Prisoner Ombudsman should be retained for reasons of transparency. The work that my Office has undertaken in the past 12 months, and the weight of historical circumstances, point to an even greater need for a Prisoner Ombudsman to provide that transparency here.

I continue to make the case for the Office to be put on a statutory footing with independent legal status. Dame Anne Owers referred in her report to the role the Office of Prisoner Ombudsman has to play in delivering reform and said that statutory independence is essential to this. I am hopeful that progress will be made on this before my next annual report.

I welcome the Review Team's interim report and look forward to their final report later this summer. They have set out a compelling series of solutions and recommendations which will make a crucial contribution to addressing the challenges faced by the Prison Service. My office shares the ambition of ensuring that prison is used in a measured, responsible way on behalf of the wider community. I fully support the assertion by the Review Team that high level political support will be essential to ensure this important work is carried out. The programme of work being led by the Director General to assist in the delivery of this change – the Strategic Efficiency and Effectiveness (SEE) Programme – needs to be properly resourced and the plan for change needs to be holistic and sequenced. I also support the Review Team when it says that "a much wider and more

67%...

...of those surveyed in a public opinion poll commissioned across the UK said that prison was not likely to reduce offending.

Prison Reform Trust: Bromley Briefings Prison Factfile - December 2010

comprehensive change programme" than the SEE programme is required and their call for external expertise in problem-solving.

We have an opportunity now to do things differently and we must take it. We will play our part in delivering the change that is needed.

It remains a major concern to me that young people, under the age of 18, continue to be detained at Hydebank Wood rather than in the Juvenile Justice Centre at Woodlands. Independent reports and our own contacts with these young people have highlighted that the regime available to them at Hydebank Wood - despite efforts to improve it - falls far short of what can be delivered at Woodlands. Ensuring that all under 18s serve their sentence at Woodlands Juvenile Justice Centre must form part of the way forward and I welcome that the Review Team has also recommended this.

As I come to the end of my third year in office, I would like to thank colleagues from across the criminal justice system for all the time and insights they have shared with me. I would like also to thank the Director General of the Prison Service and his staff for supporting and co-operating with our investigations. It is very much our wish that our work makes a positive contribution to the efforts of all of those trying to deliver an efficient and effective service.

This years audit of both the Prisoner Ombudsman Complaints and Death in Custody investigation processes achieved a substantial rating. This rating means there is a robust system of risk management, control and governance which should ensure that objectives are fully achieved and is only achieved in 5% of all public sector organisations.

This reflects the huge effort that has gone into improving operations and making the Office of Prisoner Ombudsman responsive, efficient, and ready to make a distinctive contribution, as work to modernise and reform the prison system gathers pace. For this I offer my thanks and gratitude to all of my team for their hard work and commitment.

Pauline McCabe
Prisoner Ombudsman
June 2011

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.

BUSINESS OBJECTIVES :

OBJECTIVE ONE:
INDEPENDENT

To further develop and maintain prisoner confidence in the independence and objectivity of the Office of 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 highlight to stakeholders the learning from investigations; to provide an effective and courteous service to all stakeholders; to positively influence the implementation of recommendations that improve service delivery; to answer any family questions about a death in custody and to meet the needs of the Coroner.

OBJECTIVE FIVE:
COMMUNICATION

To maximise awareness of the role of the Prisoner Ombudsman with 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.

FOREWORD BY THE PRISONER OMBUDSMAN
MISSION AND BUSINESS OBJECTIVES
COMPLAINTS INVESTIGATIONS
DEATH IN CUSTODY INVESTIGATIONS

Prisoner Ombudsman Costs 2010/2011

	£k
Staffing Costs	475
Accommodation Costs	61
Professional Advice[1]	62
Other running costs[2]	62
Total	**660**

[1] Professional advice includes legal advice, clinical reviews, other specialist reviews and reports, internal audit, design and PR support.

[2] Running costs cover a range of activities including printing of documents, stationery, staff travel costs, training.

An effective complaints system has a crucial role to play in managing frustrations and encouraging acceptable behaviour, by giving prisoners an appropriate model for resolving difficulties and problems.

[3] Ineligible Complaints - for a complaint to be eligible it must first progress through the Prison Service Internal Complaints Process

[4] An average of 122 Foreign National Prisoners were held in prison in Northern Ireland in 2010/11, according to the Northern Ireland Prison Service

COMPLAINTS INVESTIGATIONS

Figure 1.
Prisoner Complaints

OVERVIEW

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

As can be seen from Figure 1, there were 1,187 prisoner contacts with the Prisoner Ombudsman in 2010/2011, nearly double the amount in the previous year.

OF THESE CONTACTS:

- 389 (54%) were ineligible complaints[3], representing an increase on last year's 349 ineligible complaints
- 470 were advice calls, over double the advice calls dealt with last year
- 328 were eligible complaints, again more than double the 144 eligible complaints received in the previous year

While we know from prisoner contacts that there remain issues with progressing complaints through the Prison Service Internal Complaints Process, the fact that the level of ineligible complaints has dropped from 70% last year to 54% this year may reflect improved prisoner access to, and confidence in using, the internal complaints process.

FOREIGN NATIONAL PRISONERS

In the last year, 11 complaints, or less than 2% of all complaints received, were from Foreign National Prisoners, who make up around 8%[4] of the prison population.

We have held information sessions for Chinese, Lithuanian and Polish prisoners throughout the last year in order to ensure there is awareness of the complaints handling process. We are also expanding our freephone service to include a **multi-lingual service** from June 2011.

The Prisoner Ombudsman has streamlined the first stage of the complaints process in order to deal with the increased volume of complaints and to help speed up turnaround times.

ORIGIN OF COMPLAINTS

As can be seen from Figure 2, some 61% of all complaints came from Maghaberry prison, which is broadly in keeping with the percentage of the overall prison population housed there, which is roughly 55%.

Figure 2. Complaints Statistics					
	06/07	**07/08**	**08/09**	**09/10**	**10/11**
Total Complaints Received	**252 (246 est)**	**207 (246 est)**	**337 (139 est)**	**493 (337 est)**	**717 (493 est)**
Complaints received by Establishment					
Maghaberry	202 (80.1%)	130 (62.8%)	213 (63%)	303 (62%)	439 (61%)
Magilligan	41 (16.3%)	27 (13%)	98 (29%)	140 (28%)	192 (27%)
Hydebank Wood Female	6 (2.4%)	44 (21.2%)	21 (6%)	21 (4%)	35 (5%)
Hydebank Wood and YOC	3 (1.2%)	6 (3%)	5 (2%)	29 (6%)	51 (7%)

est = Estimated

Some 27% of complaints came from Magilligan prison, where around 31% of the prison population is housed.

Female prisoners at Hydebank Wood make up 3% of the total prison population and comprised 5% of all complainants, although some prisoners raised more than one complaint.

Male prisoners at Hydebank Wood account for 7% of all complaints but make up 13% of the total prison population.

There were no complaints from juvenile (under 18) prisoners.

The Prisoner Ombudsman has met with the Juvenile prisoners and held information sessions to ensure there is a good awareness of the complaints system and to bring any concerns prisoners may have about using the system to the attention of the Governor.

TIME TAKEN TO INVESTIGATE COMPLAINTS

- The Prisoner Ombudsman's **Terms of Reference** require that complaints investigations are completed and the final report sent to the prisoner within 18 weeks of the complaint being received.
- Two-thirds of complaints received were investigated, and a response issued to the prisoner, in less than 18 weeks. Around 75% were issued in less than 24 weeks.

COMPLAINTS PROCESSED

- A total of 285 complaint investigations were completed in 2010/2011, including 53 complaints which were carried over from the previous year.
- At the year-end there were 99 complaint investigations ongoing.

- The Office believes that while some complaints are complex and take a significant period of time to investigate properly, this 18-week period is too long for the vast majority of complaints and has set an internal, challenging target of 12 weeks.
- Given the very significant increase in prisoner contacts and in particular the increase in eligible complaints, the Office has not completed as many investigations within the 12-week period as it would have liked. We met the 12-week target in almost one third of cases.

RECOMMENDATIONS MADE AND IMPLEMENTED

- In the last year, the Office made a total of 230 recommendations to the Prison Service as a result of 285 investigations.
- At the year-end, responses were awaited in relation to 21 recommendations.
- Of the remaining 209 recommendations, a total of 187 recommendations, or 90%, were accepted by the Prison Service, 142 of those recommendations (76%) have been confirmed by the Prison Service as implemented.

TRENDS AND PATTERNS IN COMPLAINTS

OVERVIEW

The issues raised in complaints are many and diverse. Figure 3 gives a complete breakdown.

Figure 3. Complaint Topic Areas	
Access to Regime Activities including Education, Gym, Work	23
Adjudications - process issues and decisions	12
Adverse Reports Awarded	12
Alleged Assaults	25
Alleged Discrimination	8
Alleged Harassment/Bullying by other prisoners	7

Figure 3. Complaint Topic Areas	

Assessments and their impact on release	5
Association - lack of or entitlement to	13
Complaint Procedure	29
Disability needs not being addressed	2
Drugs - testing process	6
Food - dietary requirements not being addressed	18
Foreign National Issues	2
General Conditions - heating, lighting etc	73
Health & Safety Issues	11
Home Leave decisions	18
Lock Down - number and duration of	39
Mail - time to send/receive	15
Medical - cancelled appointments	31
Night procedures - checks and noise	34
Pre-release Arrangements	6
Property and Cash - items lost or ability to have items in prison	49
Regime Level (including PREPS)	33
Religion - Access to Services	4
Rule 32 - decisions to put on	3
Searching - full body search arrangements and removal of items during searches	30
Security - classifications	13
Segregation - process of	1
Self Harm interventions	6
Sentence Calculation	6
Sentence Planning	1
Staff attitude, behaviour, comments, bullying	64
Telephone - access to and credit for	11
Transfers and Allocations between houses	51
Tuck Shop - availability and prices	14
Visits - cancellation of and time on visit cut short	27
Wages - discrepancy between work done and wages	15

LOCKDOWNS AND IMPACT ON REGIME

The single biggest issue featuring in complaints in the last year, and the issue that has caused the Prisoner Ombudsman the most concern, is the significant number of lockdowns and periods of restricted regime that prisoners have experienced, along with the consequent failure to deliver privileges earned under the PREPS scheme. Complaints about unscheduled lockdowns, loss of association time and loss of privileges totalled 85. 54 eligible complaints were investigated.

The main reason for the lockdowns has been staffing deployment arrangements and working practices. It is not acceptable that, particularly given the significant staffing costs, the Prison Service is not able to provide all prisoners with the full regime they have earned through PREPS and that there have been additional lockdowns on an ongoing basis.

The Prisoner Ombudsman is aware of steps now being taken by the Director General through the Strategic Efficiency and Effectiveness Programme to address the staffing agreements, working practices and deployment arrangements that result, amongst other things, in lockdowns.

The Ombudsman also welcomes the prominence that has been given to addressing these staffing issues by Dame Anne Owers and the Prison Review Group in their interim report published in February 2011.

NIGHT CHECKS

In the last year the Prisoner Ombudsman has received 34 complaints about the two hourly headcount checks carried out throughout the night across the prison estate in Northern Ireland. 28 eligible complaints were investigated.

Prisoners complained that the checks disturbed their sleep and were unnecessary.

The issue of two hourly night checks was one that was commented on in a HMCIP/CJINI Magilligan Inspection Report.

In responding to the complainants, the Prisoner Ombudsman fully accepted that the two main body checks, one between 10pm and 11pm and the other at 7am, are essential and proportionate.

The Prisoner Ombudsman acknowledged that additional checks may be necessary for the highest risk Category A prisoners and are absolutely necessary for prisoners deemed to be vulnerable or at risk for a particular reason and for those on a SPAR.[5]

The Prisoner Ombudsman also noted that it may be the case that there may be particular circumstances where local discretion to carry out additional checks might be exercised at particular times. This might occur, for example, where there are specific concerns about drugs in circulation or following a death in custody. However, for the vast majority of prisoners, the Ombudsman supported the view of the Criminal Justice Inspectorate, and the practice in England, that it is not necessary to carry out the additional checks throughout the night.

The Prisoner Ombudsman noted that any prisoner who becomes unwell or requires assistance during the night may use their in-cell call bell and will be attended to by an officer.

[5] SPAR - the name of the process for "Supporting Prisoners at Risk".

FAMILY CONTACT

The most significant punitive effect of being sent to prison is the loss of freedom and the deprivation of contact with family and friends.

The importance that many prisoners place on maintaining family contact is reflected in the number of complaints received relating to visits being cancelled or cut short (27), mail being delayed or lost (15), and problems with access to the telephone (11). 28 eligible complaints about maintaining family contact were investigated.

Recommendations by the Prisoner Ombudsman have resulted in an overhaul of the way that mail is processed in Maghaberry and also, in a number of instances, to the organisation of family visits.

Prisoners and families, including children, look forward very much to prison visits and cancellation at short notice or reduced visit time, can cause great disappointment.

It is the view of the Prisoner Ombudsman that every effort should be made to support family contact and she, therefore, supports full and consistent implementation of the Prison Service Family Strategy.

Research shows that maintaining family contact whilst in prison reduces the likelihood of re-offending by 39%. Regrettably 45% of prisoners in the UK lose contact with their families while in prison.

Prison Reform Trust: Bromley Briefings Prison Factfile - December 2010

COMPLAINTS ABOUT STAFF

Almost 90 complaints were received about staff behaviour. 29 eligible complaints were investigated. A total of 25 of these were alleged assaults, often connected with the application of control and restraint procedures. Some 64 concerned decisions made by staff that were felt to be unfair or inconsistent, use of offensive or inappropriate language, alleged bullying, unfair treatment or treatment not consistent with Prison Service policy.

It is important to note, in this context, that there is evidence in many complaints of staff being helpful and supportive to prisoners.

Whilst evidence of unacceptable behaviour by some staff was found, many complaints against staff would have been avoided if the officers concerned explained properly to prisoners the reasons for their decisions and were prepared to listen to difficulties and concerns.

Staff language and attitudes evident in recorded internal responses to complaints are, at times, inappropriate and unhelpful and lack evidence of a wish to resolve difficulties where this is achievable.

It is a matter of concern also that decisions, which might reasonably be considered to be unjust, are only exceptionally overturned by more senior staff.

TRANSFERS AND ALLOCATIONS

Some 51 prisoners brought complaints because they believed that they should have been progressing more quickly through the various residential houses. 22 eligible complaints were investigated.

These related to moving to the lifer wing in Erne House, progressing to Foyleview Resettlement Unit or the Pre-Assessment Unit in Belfast, or to Braid and Wilson Houses, where conditions and/or the regime may be more favourable.

In these cases, investigations raised issues about the outcome of progression applications not being communicated to prisoners in a timely manner and a lack of information given to prisoners about why decisions were made.

In some cases, incorrect or confusing information was provided. There were also concerns around consistency in the weight given to minor breaches of discipline taking place, in some cases, many months previously. Often places are limited in houses that prisoners are trying to progress to and decisions are consistent with prison service policy, but need to be explained.

The Prisoner Ombudsman has therefore recommended that the criteria for lifer prisoner progression be clarified so that decision making could be seen to be transparent and fair.

In many instances, providing a full explanation to prisoners about the action taken - and reasons why - was determined to be the only action needed.

In 2007/08, more than

55,000

people successfully completed community payback sentences. This amounts to over

eight million hours of labour,

which was used to benefit the community.

Prison Reform Trust: Bromley Briefings Prison Factfile - December 2010

PROPERTY AND CASH

A total of 49 complaints related to property and cash were received and 27 eligible complaints were investigated. Complaints covered:

- property going missing from cells, including when prisoners move location within a prison or move between prisons
- the property a prisoner is allowed to have while in prison
- inability to send money to family
- access to a computer in cell to work on an OU course
- damage caused to property and claims for compensation

There are very necessary rules about the property that is allowed within prison, for security reasons and because prison management need to ensure that prisoners do not have a considerable amount of personal property that might then make them susceptible to bullying. Complaints often relate to the reasonableness of prison policy and the application of it. Often it is the case that prisoners simply have not been told the reason why an item has been refused.

In relation to property going missing from cells, including when a prisoner moves location, sometimes it is not possible to establish what happened to the property. However, on a number of occasions, items were found when the Prisoner Ombudsman began to investigate and were able to be returned safely to the prisoner.

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.

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

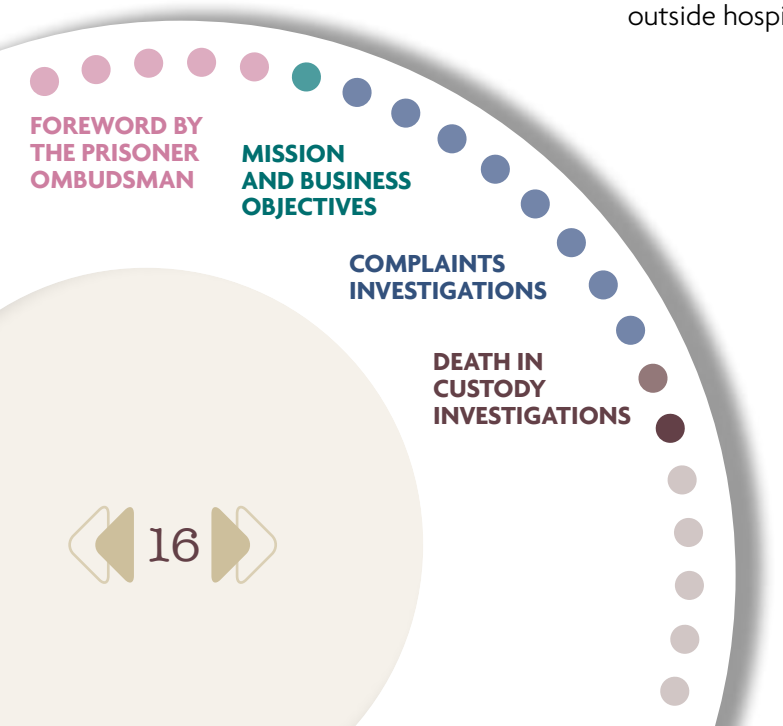
Investigation by the Prisoner Ombudsman of prison deaths ensures vital independence and transparency and helps the State to meet its obligations in respect of the European Convention on Human Rights. Other key objectives of every investigation are to provide answers for families anxious to fully understand the circumstances of the death of a loved one; to identify opportunities for organisational learning that will prevent other deaths; and to inform the work of the Coroner.

REMIT OF INVESTIGATIONS

The delivery of healthcare within prisons was transferred to the South Eastern Health and Social Care Trust in October 2008.

Whilst responsibility for the investigation of prisoner complaints about healthcare was transferred to the Commissioner for Complaints, agreement was reached that the Prisoner Ombudsman would continue to have overall responsibility for the investigation of healthcare aspects of death in custody investigations. Matters concerning the application of Prison Service policy and practice, staffing issues and health care 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.

Families are updated, at appropriate intervals, on emerging information and the progress of an investigation.

The purpose of this family liaison is to:

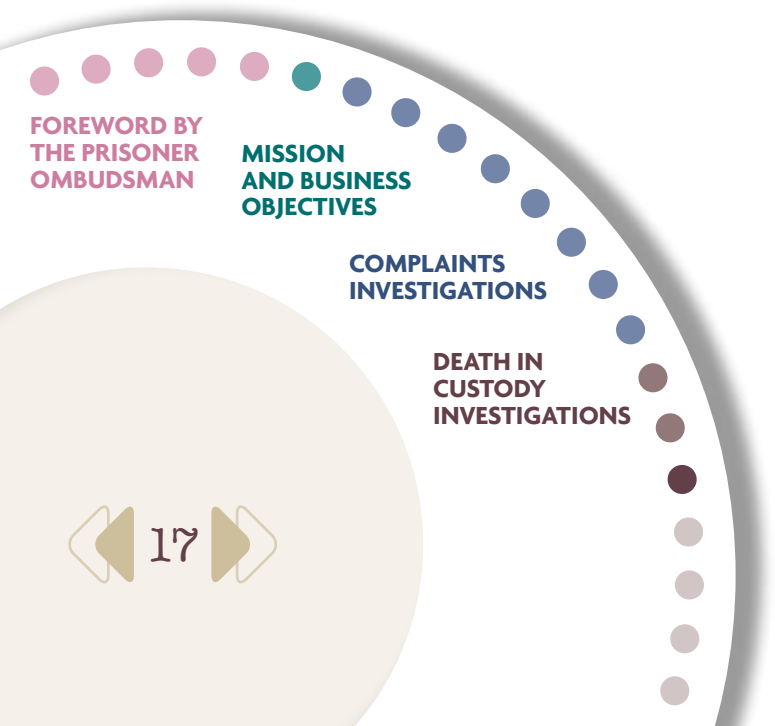
- meet at an early stage to discuss family concerns and questions
- keep families up to date on emerging findings and progress
- ensure that investigation reports address family concerns and questions
- give the family an opportunity to discuss the draft investigation report
- agree arrangements for report publication

WORKING WITH KEY STAKEHOLDERS

When carrying out a death in custody investigation, the need to keep the South Eastern Health and Social Care Trust fully informed of progress and any emerging issues is taken very seriously.

There is also liaison with the Trust over issues such as the cancellation of hospital appointments or the transfer of information between hospital, or the community, and prison.

The Prisoner Ombudsman also meets the Regulation and Quality Improvement Authority to discuss healthcare issues.



DEATHS IN CUSTODY SINCE 1ST SEPTEMBER 2005

At the time of going to press, there have been 29 deaths in Northern Ireland prisons since September 2005. A total of 28 of these prisoners were male and one was female. Of these, 10 were in custody in Magilligan prison, 16 in Maghaberry prison and three in Hydebank Wood Prison and YOC.

The apparent causes of death were as follows:

Natural Causes/illness	12
Fresh water drowning	1
Drugs-Related	3
Death by Suicide	10
Accidental *(as a result of a fall outside of prison)*	1
Head Injury *(as a result of an assault outside of prison)*	1
Legionella	1

DEATH IN CUSTODY INVESTIGATIONS MANAGEMENT

When the Office of Prisoner Ombudsman was asked to assume responsibility for investigation of deaths in custody in 2005, no additional staff or resources were provided to support this additional and very important area of work.

This resulted in a backlog of cases and unacceptable delays in the time taken to complete what can be complex investigations.

When Pauline McCabe took up the position of Prisoner Ombudsman she secured some additional funds to support these investigations. In October 2009, the Office secured one additional Senior Investigating Officer and this, along with other organisational changes, has helped to clear the backlog of cases. It remains the case that resource limitations significantly impact upon the time taken to complete investigations and report findings.

Since taking up post in September 2008 the Prisoner Ombudsman has completed investigations into 14 deaths in prison custody.

A further report was sent to the Prison Service at the end of March 2011.

Investigation into six deaths (including two deaths in Hydebank Wood Prison and YOC and one death in Maghaberry in May 2011) are ongoing.

All **death in custody investigations reports** are published on the Office website unless there is an exceptional reason for not doing so.

DEATHS IN CUSTODY IN 2010/11

In 2010/2011, a total of nine death in custody investigations were completed and a further report[6] is currently with the Prison Service.

[6] This report into the death in custody of Allyn Baxter was published on 15 June 2011.

The nine reports that have been completed in 2010/11 are detailed below:

APRIL 2010
Charles Devine

MAY 2010
Richard Gilmore

JUNE 2010
Martin Harper

AUGUST 2010
George Armstrong

OCTOBER 2010
Prisoner A
John Deery

NOVEMBER 2010
Paul Henderson
Prisoner B

FEBRUARY 2011
Prisoner C

SOME KEY ISSUES ARISING FROM DEATH IN CUSTODY INVESTIGATIONS

Some of the key issues arising from the death in custody investigation reports completed in 2010/11 included family support arrangements, arrangements for debriefing staff after a death in custody, healthcare issues, care of vulnerable prisoners and maintaining a drug free environment. Some of these are set out in more detail on the following pages.

FOREWORD BY THE PRISONER OMBUDSMAN
MISSION AND BUSINESS OBJECTIVES
COMPLAINTS INVESTIGATIONS
DEATH IN CUSTODY INVESTIGATIONS

HEALTHCARE RELATED ISSUES

- Access to healthcare services and a General Practitioner (GP) including out of hours services.
- Appropriate use of GP expertise and visiting psychiatrists, in the management of prisoners with mental health problems.
- Roles, responsibilities and professional competence of healthcare staff, including night-shift staff, and their training and ongoing personal development.
- Processes for prisoner appointments at outside hospitals and the need for a fit for purpose process for booking the Prisoner Escorting Group to take prisoners to hospital appointments.
- Record keeping and use of EMIS[7] including where a prisoner fails or refuses to attend for an appointment/examination.
- Medicine management.
- Availability of staff to push a wheelchair to healthcare in circumstances where one is required.
- Adequacy of information provided on committal to foreign national prisoners about healthcare arrangements.
- Arrangements for requesting and cancelling ambulances.
- Compliance by all GPs working in the Prison Service with the current National Institute for Health and Clinical Excellence (NICE) guidelines for Northern Ireland.
- Issues of concern identified in the Colin Bell death in custody investigation report, were repeated again, including:
  - the need for conversational checks
  - briefing and training of staff
  - hand-over arrangements
  - record keeping
  - the role of managers in checking that systems are in place
  - the need for time out of cell and a purposeful regime for vulnerable prisoners
  - the need for each vulnerable prisoner to have a multi-disciplinary care plan and a care manager
  - need for ongoing and robust self audit by the Prison Service to ensure vulnerable prisoners are kept safe.
- Gaps in the Self Harm and Suicide Policy.
- Use of the SPAR booklet.
- Attendance at multi-disciplinary case conferences.

[7] EMIS - the Electronic Management of Information System for prison healthcare records.

MAINTENANCE OF A DRUG-FREE ENVIRONMENT

- Testing arrangements including the use of the latest technology.
- Arrangements for the notification of drug test results to Healthcare staff and the Offender Management Unit.
- Maintenance of drugs free wings and support for prisoners trying to remain drugs free.
- Cell search arrangements to minimise the opportunity for drugs to be concealed or disposed of.
- Supervision arrangements following a serious drug related incident.
- The adequacy of security in and around visits areas.
- Handover arrangements between day and night shift staff, in particular, sharing of concerns about drug availability and use.
- Policy and guidance for staff around drug management issues.
- Self medication arrangements.

72%...

...of male and

70%...

...of female sentenced prisoners suffer from two or more mental health disorders.

Prison Reform Trust: Bromley Briefings Prison Factfile - December 2010

MONITORING IMPLEMENTATION OF RECOMMENDATIONS

In 2010/11, a total of 79 recommendations were made to the Northern Ireland Prison Service as a result of the nine death in custody investigations.

More than 90 % of these recommendations were accepted either fully or in part by the Northern Ireland Prison Service or the South Eastern Health and Social Care Trust [SEHSCT] and an action plan developed.

The Prisoner Ombudsman requests updates on the implementation of these recommendations in line with the Prison Service action plan.

In February 2011, in her interim report, 'Review of the Northern Ireland Prison Service', Dame Anne Owers said that:

"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. ....

There should therefore be an early review of the recommendations, discarding those that are no longer relevant or are time expired, brigading into topic areas those that remain, identifying dependencies within the recommendations and with the change programme, and prioritising and timetabling action over a period of time. Inspectorates and monitors in return will expect real and measurable outcomes."

In light of Anne Owers' comments, and in order to support the development of a more strategic and joined up approach to service development, as evidenced in the Prison Service Strategic Efficiency and Effectiveness Programme and the SEHSCT Improvement Plans, the Prisoner Ombudsman has decided, for the present, not to make recommendations in future death in custody investigation reports.

Instead issues of concern related to service delivery identified during the course of the investigation will be fully identified and the Prison Service and SEHSCT will be given the opportunity to address these concerns as part of the above programmes for change. This decision will be kept fully under review to ensure that areas of concern are being appropriately addressed, prioritised and timetabled.

The Prisoner Ombudsman has also asked the Prison Service and SEHSCT to ensure that outstanding recommendations from previous death in custody investigation reports are captured as part of these programmes for change.

It is of concern that there are recurring issues in death in custody investigations, which, if they had been addressed fully, might have prevented subsequent deaths.

22nd Floor, Windsor House, Bedford Street, Belfast BT2 7FT
T 028 9044 3982 **F** 028 9044 3993 www.niprisonerombudsman.gov.uk

www.niprisonerombudsman.gov.uk