The Prisoner Ombudsman for Northern Ireland

ANNUAL REPORT

April 2009 - March 2010

Front Cover Image:
Prisoner Ombudsman meets the new Justice Minister David Ford at Castle Buildings, **May 2010**

Contents

FOREWORD BY THE PRISONER OMBUDSMAN 04

STATEMENT BY THE PRISONER OMBUDSMAN 06

PRISONER OMBUDSMAN'S TEAM 12

MISSION AND BUSINESS OBJECTIVES 14

DEATH IN CUSTODY INVESTIGATIONS 22

COMPLAINTS HANDLING 28

COMPLAINTS CASE-STUDIES 40

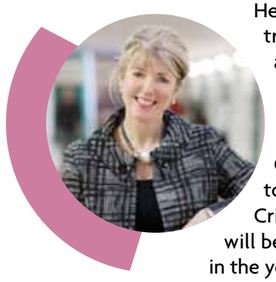
APPENDICES

Terms of Reference for Investigation of Complaints 44

Terms of Reference for Investigation of Deaths in Prison Custody 46

FOREWORD BY THE PRISONER OMBUDSMAN

As the year that is reviewed in this report came to an end, Northern Ireland welcomed the devolution of the Criminal Justice system. As you will see, laying the ground for this momentous event influenced much of the work of my Office in 2009/2010.



Helping to ensure the transition goes smoothly, and using the opportunity this provides to maximise the contribution an independent Prisoner Ombudsman can make to a fair and impartial Criminal Justice system, will be central to my efforts in the year ahead.

The single most important element in doing this will be to secure independent legal status for the Office of Prisoner Ombudsman.

I devoted considerable time in 2009/2010 to talking to all political parties and discussing the importance of putting the Office on a statutory legal footing. It was gratifying to see the need for this reflected in the Hillsborough Agreement, with its call for a review of the status of the Office. I will continue to draw attention to the need for this important change.

There has been much discussion in recent times of the need for reforms in the Prison Service and the requirement to put a greater focus on purposeful regime and the rehabilitation of offenders. Again, the provision in the Hillsborough Agreement for a review of the conditions of detention, management and oversight of all prisons, is welcome and my team looks forward to contributing to this important work.

With the devolution of Criminal Justice came the devolution of the associated budget. I believe that being in control of spending will act as a further spur to reform.

It is vital that rehabilitation and reducing reoffending rates are central to such reform. This is, of course, in line with the 2008 Criminal Justice Order, which sets out public protection proposals requiring much greater attention be given to the rehabilitation of prisoners.

Following the transfer of responsibility for healthcare in prisons to the South Eastern Health and Social Care Trust in October 2008, my Office continued in 2009/2010 to work with the Trust, as well as the Prison Service on this critical aspect of service delivery.

Healthcare was a central issue in a number of Death in Custody investigations completed during the year, and I have been liaising closely with the Trust, discussing issues as they emerge and helping to ensure our findings and recommendations inform the programme of work the Trust is rolling out across the Prison Service.

In total, my Office completed eight Death in Custody investigations in 2009/2010.

At the time of writing, four of these have been published and four are with the Northern Ireland Prison Service (NIPS) for factual accuracy checking.

During the year the Office received and processed far more complaints than the year before. There was a higher number and proportion of ineligible complaints, either prisoners did not know that they must first take complaints through the Prison Service's internal complaints procedure, they encountered some difficulty doing so, or they were reluctant to file an internal complaint. There was certainly dissatisfaction with the way internal complaints were handled by Northern Ireland Prison Service. However, I am hopeful that the recent streamlining by the Prison Service of the internal process from three stages to two, and other changes, will mean more complaints are resolved internally in future.

I believe the Office of the Prisoner Ombudsman made significant progress in 2009/2010 in terms of its professionalism, work rate and public standing.

Pauline meets with Justice Minister, David Ford.

I wish to thank all the Prison Service managers and staff who have assisted with our investigations and other work this year. I also offer thanks to colleagues across the criminal justice system for the opportunity to work cooperatively and supportively with them.

Finally, I pay tribute to my team for their huge efforts and for the manner in which they have risen to the challenges of the last year. I am particularly appreciative of the care and attention with which they carry out their work and the commitment they make to being helpful and responsive to all of those who rely on our service.

Pauline McCabe
Prisoner Ombudsman

STATEMENT BY THE PRISONER OMBUDSMAN

The Agreement at Hillsborough Castle in February 2010, which lays the framework for devolving control of the Policing and Criminal Justice System, called for "The powers of the Prisoner Ombudsman to be reviewed in light of experience elsewhere."

I am very much looking forward to contributing to that review. After 18 months in this post, I am more than ever convinced that the emphasis of the prison system as a whole must be on purposeful activity and reducing reoffending. Adequate and responsive mental health provision and access to drug rehabilitation programmes are also central to a modern prison system, and again, I am looking forward to working with colleagues across the system to bring about improvements in this sphere.

The devolution of Criminal Justice has not, however, handed those involved in the system a clean piece of paper. While I encounter much like-mindedness and widespread understanding of the reforms that are necessary, these have to be brought about on the basis of the prisons, the workforce and the resources that are to hand.

It is my view that this will only be achieved by drawing up a detailed, sequenced, strategic plan that will enable change to be implemented, show the benefits that will be delivered, and support requests for funding. Such a plan would also inform the Justice, Health and other relevant Ministers and enable them to justify spending against predictable returns on investment. I am concerned that rather than a systematic overview that will progress the prison system to where it needs to be, there will be a tendency to take a piecemeal approach. In this context, I welcome the announcement by the new Justice Minister on 22 April to establish a panel to carry out a review of the Northern Ireland prison system.

From my broad experience in Human Resources Management in both the public and private sector, and in the role I was privileged to play as a lay member of the Policing Board, it is evident that this strategic plan must by underpinned by cultural change, and a new national employee relationship framework.

I believe the fact that prison officers took industrial action twice last year highlights the need for such a plan. The action was hugely detrimental to prisoners, and it does nothing to enhance the standing of NIPS and the Prison Officers' Association for industrial relations to be at such a low ebb. It is critical we do not let an inappropriate culture and outmoded working practices deny Northern Ireland of the historic opportunity to create a prison system that is truly fit for purpose.

It is also vital that we recognise the efforts of the many staff who are working hard to provide a good service. It is very important prison staff who are trying to do the right thing feel they get the support they need. This again calls for a change to the organisational culture to build a critical mass of staff who are supportive of a change programme and of delivering an efficient service.

This brings me once more to the issue of the legal status of the Office of Prisoner Ombudsman. In the past year I have spoken to all the political parties to discuss how the lack of independent legal status impacts on the perceived and actual independence of the Prisoner Ombudsman, on the ability to fulfil the State's Human Rights obligations when carrying out investigations, and indeed on the efficient operation of the Office.

While I am grateful to the colleagues who have supported me in finessing a route through this bureaucracy, it is not appropriate for the operation of a public office such as the Prisoner Ombudsman to be dependent on good personal relationships in this way.

I was glad to see the political parties appreciated these points and that a commitment to review the powers of the Prisoner Ombudsman formed part of the historic Hillsborough Agreement.

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I am looking forward to contributing to this review, which I firmly believe must be framed in the context of the new realities in Northern Ireland's prisons. I also believe the review must be carried out and implemented as a matter or urgency. For one, the devolution of Criminal Justice means the impetus and the opportunity is at hand. For another, devolution of Criminal Justice will not play its part in creating a modern, post-sectarian society if power is transferred, but the systems and processes remain the same.

My experience of talking to people at all levels across the prison system tells me there is a general recognition that change is needed. There is also evidence of a willingness to make this change, as exemplified by some of the recent amendments to prison rules. These have seen the number of stages in the internal complaints procedure cut from three to two, and the role of residential managers increased. While I welcome this, it will only achieve its objective of streamlining and increasing confidence in the internal complaints system if it is operated on the basis of a real belief in the value of an effective system for dealing with complaints in a modern prison system.

In 2009/2010, the Prisoner Ombudsman saw a large increase [57%] in the number of complaints that were deemed ineligible because the prisoner concerned had not exhausted the internal complaints procedure. This is very worrying, as it speaks of a reluctance to use the internal process. It will be interesting to see if the changes to prison rules help here.

In February, my Office took over responsibility for dealing with visitors' complaints. Again, I feel this is an important plank of an independent complaints process. I know from my discussions with the families and friends of prisoners that they are sometimes reluctant to complain to the Prison Service because

Pauline meets with Prison Officers at Howard House, Magilligan.

of a belief that visits, or their family member in prison may be affected. There is a substantial body of evidence which indicates that maintaining family links has a significant impact on the eventual outcome for a prisoner in terms of stability and fixed residence on leaving prison. And there is no doubt that those benefits cut both ways, being very important for families, and especially for children.

Of all the duties of the Prisoner Ombudsman, the investigation of a Death in Custody is the most sensitive. The unexpected death of a loved one in prison raises concerns and questions about the causes and the circumstances. Providing an explanation to the family and looking into any particular concerns is at the heart of Death in Custody investigations.

One of the saddest aspects of the investigations into Death in Custody completed since I began my term in office is that many recommendations had been made before. This highlighted the need for there to be a robust process for implementing recommendations and a system for tracking to ensure implementation had occurred. Whilst I appreciate it takes time and effort to draw up Action Plans, implementing recommendations remains an area where improvement is needed. I am firmly of the view that the backlog of recommendations can best be dealt with in the context of the comprehensive, sequenced, strategic plan mentioned earlier.

When I took up the post of Prisoner Ombudsman, one of my first priorities - for the sake of the families, and to try and stop the same circumstances arising again - was to clear the backlog of Death in Custody investigations. In 2009/2010, my colleagues and I made good progress, completing eight investigations. Of these, four have been published and four are with the NIPS for factual checking. I am determined to make further improvements and get to the point where Death in Custody Investigations take less time to complete.

In 2009/2010, I held regular meetings with the Prison Officers' Association and have written in the in-house staff magazine to keep staff up to date on progress, and outcomes, of Death in Custody investigations. I believe that such open communication can help increase receptiveness to recommendations that need to be implemented. I also make particular efforts to draw attention to good practice where I find it.

One relatively new area of oversight for this Office is monitoring the use of the synthetic pepper spray known as PAVA spray. At the time of writing, NIPS has twice recently authorised the deployment of this spray. In the event it was not used, but there is an agreement that the Prisoner Ombudsman will investigate all authorisations. I will do so and report back in due course.

Also at the time of writing, industrial action is taking place in Maghaberry Prison. Former Governor Tony Pearson, who developed an Action Plan for NIPS in response to my report on the death of Colin Bell, carried out an audit of the recommendations and reported again in March 2010. In the meantime, Steve Rodford, who was brought in from outside Northern Ireland to institute reforms, left the post after only six months.

This was very regrettable, since he brought in fresh thinking and different experience, which is exactly what is needed to bring about reform. Following Governor Rodford's resignation, the need for transparency is greater than ever, as is the need to face up to the management and leadership challenges.

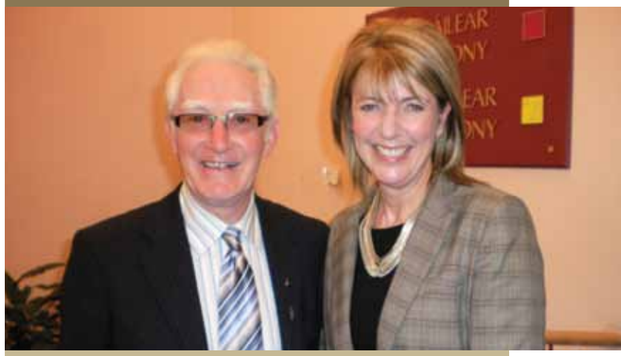
Another major area that is central to a modern prison system is the investigation of prisoner complaints. Most of us would agree the best possible outcome from a sentence is that the prisoner does not reoffend. An effective complaints system is crucial in managing frustrations and encouraging acceptable behaviour, by demonstrating that the system is fair, reasonable and proportionate.

After putting in place measures to increase confidence in the system, the number of complaints received overall increased dramatically in 2009/2010. However, it is still the case that very few complaints come from Hydebank Wood. There is also concern at the way in which the number of ineligible complaints has risen. A detailed breakdown of the complaints figures, where they came from and what they were about is on page 32.

As this shows, NIPS has been increasingly receptive to the recommendations made as a result of complaints investigations, and I welcome this. I will continue to work with NIPS to ensure that the internal complaints process operates efficiently and to make sure recommendations that are accepted go on to be implemented. A full breakdown of complaints is published in each edition of Inside Issues, our newsletter for prisoners.

One significant area where reform is currently in train is the Strategy for the Management of Women Offenders. At the heart of this is a new women's centre with a fresh approach to meeting the needs of women offenders, which was officially opened by Criminal Justice Minister Paul Goggins in January. The Inspire Centre, the first of its kind for Northern Ireland, provides a range of programmes tailored to meet the individual needs of female offenders. In this pilot project, the Criminal Justice agencies are working

Pauline meets the Polish Consul, Jerome Mullen.



in partnership with the community and the voluntary sector to deliver the tailored programmes that aim to help women to deal with their offending behaviour.

The women who use the centre are on community supervision, or currently in custody but eligible for day release.

The opening of the Inspire Centre is very welcome, as are other elements of the Women Offenders Strategy that have been put in place. The danger is that this strategy becomes the exemplar for how the prison system as a whole will fail to improve, unless it is implemented in full and in the context of an overarching and coherent plan.

Another area of focus during the year has been to draw attention to the detention of those under the age of 18 at Hydebank Wood, rather than in the Juvenile Justice Centre at Woodlands. Independent reports and our own contacts with juveniles and young prisoners have highlighted a number of issues affecting young people residing in Hydebank Wood.

These include the limited regime and availability of purposeful activity, a shortage of education provision and of work opportunities, and limited emphasis on rehabilitation and resettlement.

This regime is unsuitable for children and young prisoners. I also believe it is at odds with Article 37 of the United Nation Convention on the Rights of the Child.

There are also issues with mental health provision, staff experience and training and the provision for those with learning difficulties. As discussed elsewhere, this Office receives very few complaints from Hydebank Wood. This is at odds with what I have heard from the young prisoners, signalling that there may be problems with accessing the complaints system.

I am aware of the very significant efforts being made by the Governor at Hydebank Wood to improve the regime and the support available to juveniles, which has undoubtedly delivered improvements. We are also working with the Governor to support his efforts to make the internal complaints process more accessible. I am, nevertheless, firmly of the view that all under 18's should serve custodial sentences in Woodlands, not Hydebank Wood.

I have had very helpful meetings with members of the judiciary, youth support groups and with the Minister, to discuss these issues. I welcome the fact that a Working Group was set up by Minister Paul Goggins to take forward these concerns. I will play any part I can in resolving this matter.

I have raised a number of times my concerns about the procedures for processing complaints of assault and the quality of investigations carried out. I continue to have serious concerns about how assault allegations are handled. However, there have been helpful meetings with NIPS and the PSNI to discuss the matter, and the current arrangements for reporting and investigating alleged assaults are being reviewed. I very much welcome this move.

I look forward, with great hope, to the opportunities and possibilities that the next year can bring. The Office of the Prisoner Ombudsman is absolutely committed to playing its part in working with colleagues to make sure that these possibilities are realised.

"Four in ten 10-17 year olds committed another crime within a year, whilst involved in restorative justice schemes, compared to 71% of those who had been locked up."

"Making Amends: restorative youth justice in Northern Ireland" 2009.

PRISONER OMBUDSMAN'S TEAM

Pauline McCabe
Prisoner
Ombudsman

Pauline McCabe was appointed as Prisoner Ombudsman for Northern Ireland on 1 September 2008 by the Secretary of State for Northern Ireland.

A small team of Investigators and other staff support the Prisoner Ombudsman. The Ombudsman is completely independent of the Northern Ireland Prison Service.

The Prisoner Ombudsman investigates complaints from prisoners held in Northern Ireland who remain unhappy with the answer they have received from the Prison Service.

The Ombudsman can investigate complaints from all prisoners (including, in certain circumstances, former prisoners) sentenced and remand, men and women, adults and young prisoners.

As of 1 February 2010, the Prisoner Ombudsman is also responsible for investigating complaints from prison visitors.

Complaints must first have been processed through the internal Prison Service complaints system. The Prisoner Ombudsman will take a fresh look at the complaint and decide whether it has been dealt with fairly. If a complaint is upheld the Ombudsman may make recommendations to the Prison Service to put things right, and to try and ensure the same problem cannot arise again.

Our People

Sinead Simpson
Director of Operations

Michael Hillis
Senior Investigating Officer Complaints

Clare McVeigh
Senior Investigating Officer Deaths in Custody

Pat McKinney
Investigating Officer Complaints

Wai Ki Mo
Investigating Officer Deaths in Custody

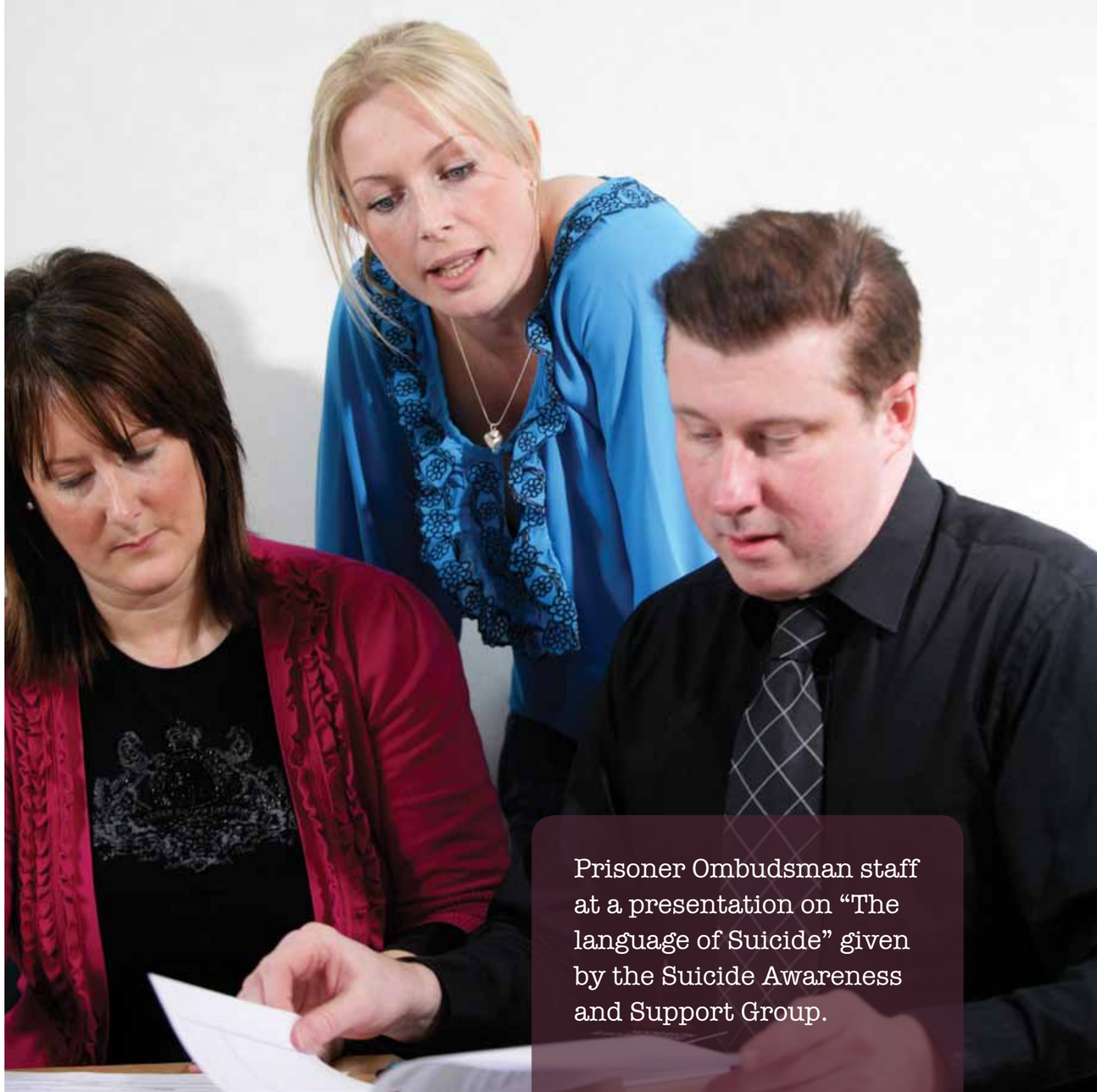
John Clerkin
Investigating Officer Complaints

Gemma Brown
Office Manager

Paula Curry
Complaints Officer

Sharon Hetherington
Personal Assistant to the Prisoner Ombudsman

Linda McIlwrath
Personal Assistant to the Prisoner Ombudsman



Prisoner Ombudsman staff at a presentation on "The language of Suicide" given by the Suicide Awareness and Support Group.

MISSION AND BUSINESS OBJECTIVES

Our Mission

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

OBJECTIVE **ONE:** To develop and maintain prisoner confidence in the independence and impartiality of the Office.

OBJECTIVE **TWO:** To further develop the investigation processes for complaints and Death in Custody investigations, ensuring high standards of investigative practice, robustness and a proportionate approach.

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

OBJECTIVE **FOUR:** To highlight the learning from investigations and influence the implementation of recommendations to help improve service delivery; to answer any family concerns about a Death in Custody, and to meet the needs of the Coroner.

OBJECTIVE **FIVE:** 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; to provide a courteous and effective service to all stakeholders.

OBJECTIVE **SIX:** To secure Statutory Footing, and to further develop the role of the Office to meet emerging needs.

Prisoner Ombudsman Costs 2009/2010

2008/09 Resource Expenditure[1]	£k
Staffing Costs	406
Accommodation Costs	89
Professional Advice[2]	98
Other running costs[3]	94
Total	**687**

[1] The Office secured an additional £90K on top of the annual budget to fund Death in Custody Investigative work. This is included in the figures above. 45k of this was made available on a non recurring basis.

[2] Professional advice includes legal advice, clinical reviews, other specialist reports, design and PR support and the cost of temporary Investigators to assist with the Death in Custody backlog.

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

OBJECTIVE ONE

To develop and maintain prisoner confidence in the independence and impartiality of the Office.

This has been achieved by ensuring that:

- All eligible complaints reach the Office of the Prisoner Ombudsman.
- All correspondence with prisoners and prison staff demonstrates the impartiality of the Office and provides evidence of an independent investigation.
- All ineligible complaints and advice calls are handled thoughtfully and professionally.
- Any procedural or quality issues identified in connection with the internal handling of a complaint are highlighted to the Prison Service.
- The role and achievements of the Office are communicated objectively through a range of different channels.
- The Office is accessible to prisoners and prison staff.

In 2009/2010, the Office put great effort into ensuring prisoners have open access to the complaints process and feel that complaints are dealt with fairly and efficiently. It is not clear whether all eligible complaints, that is complaints that have been through the internal process, but where the complainant still feels aggrieved, are brought to the Prisoner Ombudsman. The increased number of complaints submitted, does, however, suggest that prisoners have a level of confidence that the Prisoner Ombudsman operates independently of the Prison Service.

Whilst increasing the volume of complaints handled and the number of Death in Custody investigations completed, the Office has also implemented quality assurance processes to demonstrate that investigations are evidence-based and decisions made, or conclusions reached on the basis of that evidence, are objective and impartial.

Many of the complaints that reach the Office are ineligible, in most cases because the internal complaints process has not been exhausted. The internal complaints process has recently been reduced from three stages to two. It is hoped that this will both reduce the number of ineligible complaints received by the Prisoner Ombudsman and make it easier to ensure that eligible complaints do reach the Office, where a prisoner remains unhappy with the outcome.

1

OBJECTIVE TWO

To further develop the investigation processes for complaints and Death in Custody investigations, ensuring high standards of investigative practice, robustness and a proportionate approach.

Meeting this objective has included ensuring that:

- Rigorous methodologies for all investigations have been developed and implemented and that they are reviewed in line with best practice, on an ongoing basis.
- Reviews of management information, and the outputs from the management information system, are conducted regularly.
- All necessary resources to support investigations are secured.
- Effective informal resolution processes are developed.
- There is regular liaison with the Prison Service about the handling of investigations.
- Individual staff performance reviews are conducted.
- Opportunities for staff training and development are optimised.
- Legal and other professional advice is accessed, where appropriate, throughout the course of investigations.

Alongside the external measures described in Objective 1 to build confidence in the Office, a number of internal programmes were put in place to increase and further professionalise the way in which the Prisoner Ombudsman carries out investigations.

Both the complaints investigation and the Death in Custody investigation operation manuals were reviewed and further developed, in line with best practice.

All members of staff are included in regular performance review and, where appropriate, have been on accredited training courses. A system has been set up for identifying opportunities for future training and development activity that will add real value to investigative practice.

A tender exercise has taken place to secure fully independent legal services and the list of professional advisors that can be accessed, particularly in respect of Death in Custody investigations, has been reviewed and extended.

2

OBJECTIVE THREE

To ensure that the Office is efficient and compliant with relevant legislative and governance requirements.

To meet this objective we have taken steps to ensure:

- Telephone answering and administrative systems are effective and demonstrate a high level of service.
- Staff are operating to relevant legislation and policies.
- Compliance with legislation and policies is monitored.
- Summary data on eligible complaints, ineligible complaints and in connection with the Internal Complaints process is captured and discussed regularly with Prison Governors.
- Performance against business plan targets, expenditure against budget and the risk management framework are all reviewed regularly.
- Internal audits are commissioned each year and agreed recommendations are implemented.

While the Office has made headway in terms of its efficient operation in 2009/2010, more remains to be done. All telephone calls from prisoners and prison visitors are handled promptly. However, the Office has not met its aim of interviewing all prisoners within four weeks of a complaint being deemed eligible, or of passing all reports to the Prison Service for factual accuracy checking within 12 weeks. With current staffing, these targets remain challenging for the number of complaints received. Ongoing efforts are being made to achieve further efficiencies.

Similarly, while the completion of eight Death in Custody investigations was a significant achievement, the target of sending reports to NIPS for factual accuracy checking within nine months was not achieved. This was because the Office was not adequately resourced to carry out these investigations. With adjustments to resourcing now in place, the Office will be working to meet these targets for future Death in Custody investigations.

This effort will be supported by improvements in internal operations and processes made in 2009/2010, to provide a more streamlined and efficient service for handling information.

3

OBJECTIVE FOUR

To highlight the learning from investigations and influence the implementation of recommendations to help improve service delivery; to answer any family concerns about a Death in Custody, and to meet the needs of the Coroner.

In meeting this objective the Office has ensured that it:

- Produces relevant and appropriate recommendations, in response to both complaint and Death in Custody investigations, based on best practice.
- Operates a tracking system, using a range of methodologies, to ensure that complaints recommendations are implemented.
- Seeks regular updates on the progress of implementation of recommendations arising from Death in Custody investigations.
- Publishes, in line with the Prisoner Ombudsman's Terms of Reference, all Death in Custody investigation reports.
- Provides updates at appropriate intervals to families during Death in Custody investigations.
- Publishes summaries of complaint investigations.
- Meets regularly with staff of the Coroners' Office to discuss and agree the needs of the Coroner and how these can be best met.

A tracking system is now in place, and working well, for monitoring the implementation of recommendations arising from complaints. A recently introduced system for monitoring implementation of recommendations arising from Death in Custody investigations requires the Prison Service to provide regular updates on the implementation of action plans. This will be evaluated before the end of the year.

Reports of all published Death in Custody investigations have been placed on the office's website, while summaries of complaints investigations are published in Inside Issues and are included in the Annual Report.

A database of previous recommendations and other material, including prison inspection reports, has been set up so that Investigators can consider these when investigating new complaints.

4

OBJECTIVE FIVE

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; to provide a courteous and effective service to all stakeholders.

To meet this objective we have been working to ensure:

- Prisoners are informed (in writing) of the details, findings and recommendations of each complaint investigation.
- Families are contacted by Investigators at least every eight weeks to inform them of the progress of Death in Custody investigations.
- Death in Custody Reports are forwarded to all stakeholders who have an interest in, or whose work is informed by, the findings and recommendations.
- Prison Governors and staff are kept informed about the work of the Prisoner Ombudsman.
- All external stakeholders are kept up to date on Prisoner Ombudsman service developments in which they have an interest.

The Prisoner Ombudsman and her staff meet with the family following a death in prison and, as appropriate during an investigation and discusses the findings and recommendations.

Meetings are also held with prison staff and with the Prison Officers' Association (POA) to discuss progress, developments or concerns in connection with the work of the Prisoner Ombudsman. The Prisoner Ombudsman also contributes articles to the prison staff newspaper.

Copies of completed Death in Custody investigation reports are sent, prior to publication, to the Northern Ireland Prison Service and to the South Eastern Health & Social Care Trust, the Criminal Justice Inspector, HM Prison Inspectorate of Prisons, the Human Rights Commission, the Equality Commission, the Commissioner for Complaints and the Regulation and Quality Improvement Authority, after the report has been sent to the Coroner.

The Prisoner Ombudsman is currently enhancing the office's communications strategy to build an understanding amongst the general public and other stakeholders, of the contribution the Office is able to make in meeting the changing needs of the Criminal Justice system post-devolution.

5

OBJECTIVE SIX

To secure Statutory Footing, and to further develop the role of the Office to meet emerging needs.

In support of this objective, the Office has worked to ensure that:

- The urgent need for the Office to be placed on a Statutory Footing is understood and supported by stakeholders and political representatives.
- Appropriate action is taken, following the devolution of policing and justice, to place the Office of the Prisoner Ombudsman on a statutory footing, as soon as possible.
- The Pilot Protocol for investigating complaints about Probation Services within prison is reviewed and a forward plan is developed, following a pilot in 2009/2010.
- Arrangements for investigating complaints from prison visitors are developed, implemented and reviewed.
- The Office contributes to the development of arrangements for the investigation of "Near Deaths".

As described previously, much effort has gone into ensuring that prisoners understand that the Prisoner Ombudsman is independent and impartial. Significant progress has been made in this respect. However, the Prisoner Ombudsman does not have a statutory basis in legislation.

Over 2009/2010, a number of meetings were held with political parties to discuss the importance of the Office being put on a statutory footing. As a result, the Agreement at Hillsborough Castle, cited the need for a review of the role of the Prisoner Ombudsman. Plans are in hand to meet the new Justice Minister to discuss this.

During this year a pilot exercise was undertaken to allow prisoners who had exhausted the Probation Service's internal complaint process to bring their complaints to the Prisoner Ombudsman. As yet no complaints have been received and the Prisoner Ombudsman and Probation Service are reviewing the pilot to decide what to do next.

It is very welcome that an amendment made to Prison Rules this year means that visitors to prison may bring a complaint to the Prisoner Ombudsman, if they are unable to resolve their difficulty or concern with the Prison Service. Arrangements have been put in place to provide an appropriate service to visitors who wish to bring a complaint to the Prisoner Ombudsman.

6

Prisoner Ombudsman provides a freephone service to all callers and a translation/interpretation service to assist in clarifying complaints.

DEATH IN CUSTODY INVESTIGATIONS

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 may relate to the care received in prison.

During 2009/10 the Prisoner Ombudsman implemented arrangements for an early review and scoping exercise immediately following any Death in Custody. Concerns about policy and practice are notified to the Prison Service and South Eastern Health and Social Care Trust. During the course of any Death in Custody investigation, early recommendations are forwarded to the Prison Service and the Trust, in any circumstances where it is believed this could help to prevent a similar death.

Investigation by the Prisoner Ombudsman of these sad events 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 Coroner.

Deaths in Custody since 1st September 2005

Since September 2005, there have been 22 deaths in Northern Ireland Prisons. All of these prisoners were male. Nine were in custody in Magilligan prison and 13 in Maghaberry prison. The apparent causes of death were as follows:

Natural Causes/illness	10
Fresh water drowning	1
Drugs-Related	3
Suicide	5
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

Deaths in Custody during 2009/2010

Three of the Deaths in Custody detailed above occurred in 2009/2010. Of these, two were in Maghaberry Prison and one in Magilligan Prison. In one case the prisoner died by suicide and two were due to illness/natural causes. Ten other Death in Custody investigations were carried forward from the previous year.

Eight Death in Custody investigations were completed in 2009/2010. Four of these have been reported in public and four have been sent to the Northern Ireland Prison Service, in line with the Prisoner Ombudsman's Terms of Reference, for checking of factual accuracy.

In the four published Death in Custody reports, the Prisoner Ombudsman made 39 recommendations related to Maghaberry Prison. Thirty two of these recommendations (82%) were accepted, 2 (5%) were accepted in principle and 5 (13%) were accepted in part.

At the end of the year there were five further Death in Custody investigations ongoing.

Resourcing of Death in Custody Investigations

When the Office of the Prisoner Ombudsman was asked to assume responsibility for Death in Custody investigations in September 2005, no extra 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. In October 2009, the Office secured an additional Senior Investigating Officer to support Death in Custody investigations.

Death in Custody Investigations Reports Published in 2009/10 in Custody Investigations

INVESTIGATION INTO THE DEATH IN CUSTODY OF JAMES DONARD HENRY SPEERS

Following the investigation into the death from a heart attack of Mr Speers on 18 February 2008, the Prisoner Ombudsman made three recommendations covering:

- A review of arrangements for acting on and recording responses to a doctor's request for baseline investigations and/or patient monitoring.
- A review of the arrangements for the examination of blood test results by a doctor.
- An amendment to the procedure for calling an ambulance, in order that roles and responsibilities are clear.

All three recommendations were accepted.

INVESTIGATION INTO THE DEATH IN CUSTODY OF JOHN KENNEWAY

Mr Kenneway died by suicide on 6 June 2007 after spending 122 days in the Special Supervision Unit at Maghaberry Prison.

The Prisoner Ombudsman made a total of 19 recommendations, 12 to the Northern Ireland Prison Service and seven relating to healthcare in prison.

The recommendations relate to three key areas:

- The conditions and regime in the Special Supervision Unit.
- Limiting the supply of illicit drugs in prison.
- Issues around the care of prisoners with a previous record of mental health problems and prisoners who may be at risk of self harm.

Most importantly, the Prisoner Ombudsman called for a review of progress in implementing Prison Service Action Plan, drawn up in July 2008, in response to the Prison Service Report on Minimising the Supply of Drugs in Northern Ireland Prisons.

All of the recommendations were accepted.

INVESTIGATION INTO THE DEATH IN CUSTODY OF STEPHEN DORAN

Mr Doran was in a poor state of health when he was committed to Maghaberry Prison and he was immediately transferred to the prison health care centre, where he died four days later on 6 June 2008.

The Prisoner Ombudsman made eight recommendations relating to:

- The care of seriously ill people in prison.
- Arrangements for carrying out and recording clinical observations.
- Arrangements for accessing a prisoner's previous medical history.
- Circumstances in which prisoners should be admitted to outside hospital.

The recommendations were all accepted.

INVESTIGATION INTO THE DEATH IN CUSTODY OF ALAN RUDDY

Following the investigation into the death of Mr Ruddy aged 29, in Maghaberry Prison on 31st January 2008, the Prisoner Ombudsman made nine recommendations.

Mr Ruddy died on 31 January 2008, as a result of an accidental overdose of what was described by the independent medical reviewer as a cocktail of drugs both prescribed and illicit, which had been brought in to the prison. The evidence indicated that Mr Ruddy had not intended to take his own life, but had inadvertently overdosed by taking non-prescribed pills of unknown origin.

The nine recommendations relate to:

- Healthcare assessment upon committal to prison.
- Arrangements for reviewing previous medical history and medication upon committal.
- A review of arrangements for follow-up action where prisoners attempt self-harm.
- A review of arrangements for supporting prisoners with drug addiction problems and referral to specialist services.

Two of the recommendations were fully accepted; five were accepted in part; and two were accepted in principle.

Implementation of Recommendations

When the investigation into the death of Colin Bell was published in January 2009, it was noted that the report repeated a number of recommendations that had been made and accepted, but not implemented, as result of other earlier prison investigations, inspections and reports.

In the case of each Death in Custody investigation, the Prisoner Ombudsman has now put in place arrangements to request updates on the implementation of the recommendations made, in line with the Action Plan provided by the Prison Service.

Death in Custody Investigations - Health Care Issues

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.

When carrying out a Death in Custody investigation the need to keep the 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 Commissioner for Complaints and the Regulation and Quality Improvement Agency to discuss healthcare issues.

The Prisoner Ombudsman has no responsibility for investigating the care of a prisoner whilst in an outside hospital.

Use of Expert Advisers

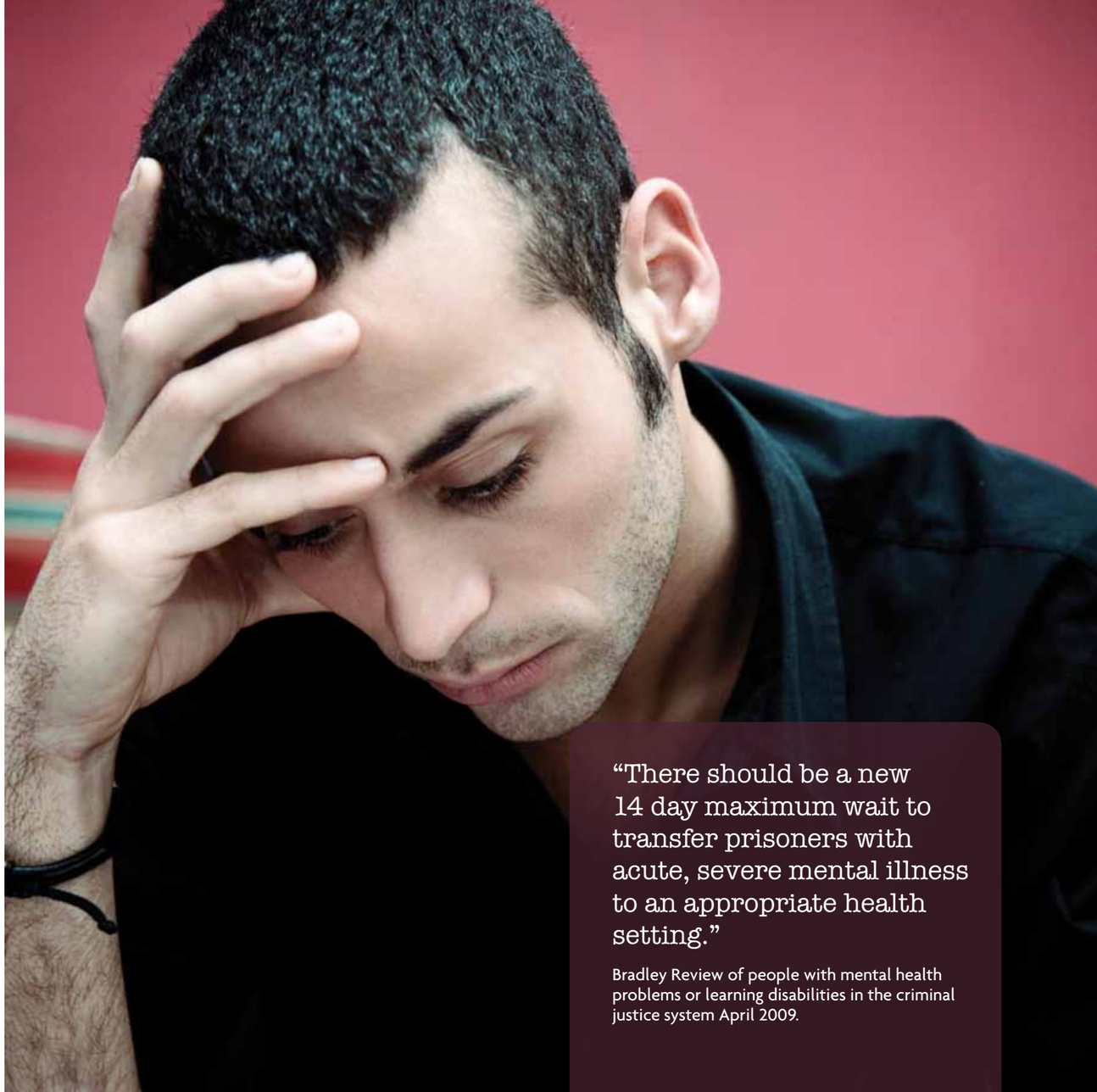
As part of Death in Custody investigations, independent, appropriately qualified experts are engaged, where necessary, to carry out a full clinical review of the healthcare provided to a prisoner, whilst in prison, and to answer questions raised by the investigation and by families.

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 has put in place family liaison arrangements. The Office 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 progress.

The aim of this family liaison work is:

- to meet at an early stage to discuss family concerns and questions;
- to keep families up to date on emerging findings and progress;
- to ensure that investigation reports address all of their concerns and questions;
- to give the family an opportunity to discuss the draft report;
- to present the final report in a way that is sensitive, and agree arrangements for publication.



"There should be a new 14 day maximum wait to transfer prisoners with acute, severe mental illness to an appropriate health setting."

Bradley Review of people with mental health problems or learning disabilities in the criminal justice system April 2009.

COMPLAINTS HANDLING

Overview

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

Figure 1. Prisoner Complaints

There were 690 prisoner contacts in 2009/2010, of which 349 were ineligible complaints, 197 were advice calls and 144 were eligible complaints.

Complaints Received and Processed

In all 493 prisoner complaints were received in 2009/2010 of which 144 were eligible and 349 ineligible complaints. At 493, the total number of complaints received is much higher than 2008/2009 when 337 were received. 47 eligible complaints were carried forward from 2008/09. The total number of complaint investigations completed in 2009/10 was 151.

Ineligible Complaints

In 2009/10 a full 70% of complaints were ineligible. This was a marked rise from 2008/09 when 59 per cent of complaints were ineligible.

This increase is a matter for concern. The most common reason why complaints were ineligible is that the internal complaints process has not been exhausted. This may be because a prisoner was unaware of the requirement to raise the complaint internally before contacting the Prisoner Ombudsman; the prisoner was reluctant to use the internal complaints process; or the prisoner had difficulty accessing the internal complaints process.

It is still the case that prisoners report they feel concerned, or have been told their privileges, visits, access to education or training, prison jobs and so on, may be affected if they make a complaint.

In 2009 the Prison Service implemented a new internal complaints process with two stages rather than three. The Prisoner Ombudsman is supporting efforts to make sure this operates efficiently. The new process requires a residential manager to meet a prisoner within 24 hours of a complaint being lodged, and any early indications are that, where the residential managers are constructive and supportive of the value of effective complaints handling, the new process works well.

Some concerns have been raised about residential managers using their seniority to influence prisoners not to pursue complaints. The Prison Service has been made aware of this and it will be monitored over the next year.

Paula takes a call on the freephone service.

Telephone Advice

In the last 12 months, 197 calls for advice were received. Some of these are relatively easy to deal with, others less so. Calls can be from prisoners who require some assistance with an issue or concern, and are not sure with whom it should be raised. Calls also come from the families of prisoners who are phoning because they are concerned for the welfare of a relative. Calls may include concerns about self-harming or allegations of assault that require immediate and appropriate action to be taken. The Prisoner Ombudsman has an arrangement in place to make immediate contact with nominated personnel at each prison if there is concern about the mental health of a prisoner and the possibility that they may self-harm.

In many instances the advice sought is about matters that prisoners could raise with Prison Officers if they felt able to do so. Regular meetings take place with Prison Governors to discuss the type of issues being raised and questions asked.

Origin of Complaints

Figure 2 shows the comparison of complaints received this year versus earlier years, against estimated figures and which prison they came from.

Maghaberry

Figure 2 shows that 62% of the 493 complaints received in 2009/2010 came from Maghaberry Prison. The high proportion of complaints is in part a reflection of the higher number of prisoners at Maghaberry, which is the main committal prison in Northern Ireland and houses 54% of the total prison population. It also houses prisoners with a mix of different security classifications, including all Category A - that is high risk - prisoners. The management of the regime within the prison has historically, to a large extent, been determined by this. Action is currently being taken at Maghaberry to achieve a more appropriate balance between prisoner regime and care needs, for each category of prisoner.

Magilligan

Magilligan Prison is a low to medium security facility, which holds a male population who have six or less years to serve. In total 140, or 28% of complaints came from Magilligan. This was 42 more complaints than 2008/09.

Hydebank Wood

At Hydebank Wood, 21 complaints were from female prisoners and 28 from male prisoners, an increase on

2008/09 when just 5 complaints were received from men. The number of complaints from young offenders under the age of 18 at Hydebank Wood was once again very low, with only one complaint received.

> In 2009/2010 steps were taken to explore why complaints from young offenders at Hydebank Wood are so low, through prisoner information sessions and in meetings with staff and management. From these sessions it was evident that young prisoners do have difficulties and problems which they do not raise through the complaints system.

Whilst a low number of complaints can be a positive indicator, it is also well-documented that barriers to accessing a complaints process can be greater for young people. The Governor at Hydebank Wood believes strongly in the value of an effective complaints system in constructively addressing problems, concerns and abuse. We continue to work with him to gain a greater understanding of both positive factors and concerns impacting upon the level of complaints.

In 2009/2010, the 21 complaints from female prisoners at Hydebank Wood was the same as 2008/09.

Again, there is evidence that female prisoners may have particular problems with accessing complaints processes and the Office has been working with the Governor at Hydebank Wood to identify and address any relevant issues. It is essential prisoners feel they can ask for a complaint to be examined without being anxious this may be held against them by staff.

Prison Visitors

The Prisoner Ombudsman took on responsibility for handling complaints from prison visitors in February 2010. Between then and the year end on 31 March, there were five complaints and two calls to the telephone advice line. Of the five complaints, four were deemed ineligible. Visitors were unaware that they need to access the one step Prison Service Visitor complaints process, before a complaint is eligible for investigation by the Prisoner Ombudsman. Further efforts will be made in 2010/11 to communicate directly with visitors to ensure that the complaints process is understood and easily accessed. The Prisoner Ombudsman looks forward to reporting on visitor complaints in next year's Annual Report.

Figure 2. Complaints Statistics

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

EST = Estimated

Issues Raised in Complaints

The issues raised in complaints cover a wide range of topics. Figure 3 gives a complete breakdown.

As shown in Figure 3 on page 28, the complaints received - and the subsequent recommendations made - range from serious issues relating to assaults, harassment and bullying, to what for some may seem minor concerns about food, access to the telephone and delays in outgoing and incoming mail. The Office takes all matters seriously, recognising that things which may seem minor can have a disproportionate impact on someone in prison. Issues that affect contact and communications with family may cause particular concern or distress.

There was a marked increase in complaints about property and cash, from 32 in 2008/2009 to 48 in 2009/2010. In particular, there were problems with confiscated items going missing and property not being handed over to nominated visitors. The Office has made a number of recommendations following investigation of these complaints, with the aim of building prisoners' confidence in the processes for placing personal property in property boxes or handing items over to visitors.

Twenty five ineligible complaints were received about medical issues. Since the transfer of responsibility for the delivery of healthcare in prison to the South East Health and Social Care Trust, responsibility for considering complaints on medical matters has transferred to the Commissioner of Complaints. All prisoners making medical complaints were advised how to access the services of the South Eastern Health & Social Care Trust and the Commissioner and offered assistance if needed.

There has been a marked increase in the number of Foreign National prisoners in Northern Ireland since the figures were first collected in July 2006. At that point 46 foreign nationals were held. This number increased steadily month by month to a peak of 157 in October and November 2008, before falling back to 98 in February 2010.

Over the first three months of 2007 an average of 47 foreign nationals were held, in the first three months of 2010, the average number was 100. The Prison Service has put significant efforts into being supportive of the particular needs of foreign national prisoners. Whilst last year 12 complaints were received about discrimination or other issues specific to the circumstances of foreign national prisoners, this year only one such complaint was received. Complaints from foreign national prisoners are included throughout the other complaint categories reported by topic.

To ensure foreign nationals can access the complaints process Prisoner Ombudsman publications have information in other languages. When a contact is received from a foreign national prisoner, a translator is available when the Investigating Officer meets the prisoner.

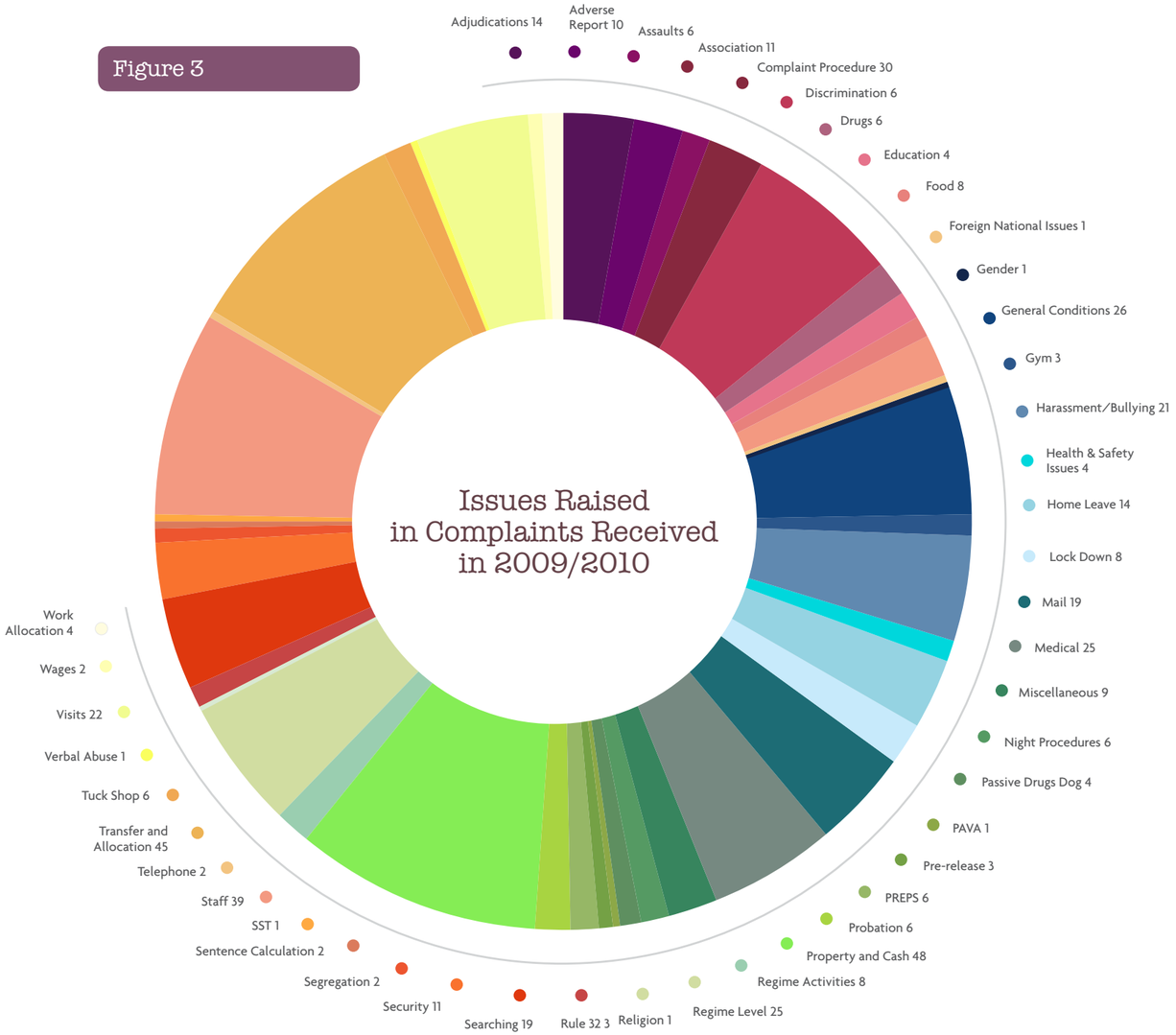
During 2009/10, the Office received 45 complaints relating to the transfer of prisoners between residential locations within a prison. Transfers may occur for a variety of operational, security or individual reasons. The Prisoner Ombudsman can help to clarify the reasons for the transfer and ensure compliance with Prison Service policy. Sometimes all a prisoner needs is an explanation of the reasons why he or she has been moved.

Regime level - Enhanced, Standard or Basic - determines the privileges to which a prisoner is entitled.

In the past year, the Office received 25 complaints about a reduction of regime following incidents such as receiving an adverse report, failure of a drugs test, or not fully participating in a sentence plan. These complaints usually involve a prisoner feeling a decision is unfair or does not comply with Prison service policy.

Complaints about searching may refer to searching of a prisoner or cell searches. Over the past 12 months, there were 19 complaints about the manner in which searches are conducted, or related matters.

Figure 3



There were also 14 complaints from prisoners who felt that decisions made in response to home leave applications were unfair.

A total of 30 complaints involved the actual operation of the Prison Service's Internal Complaints Process. In the majority of cases the issue was a delay in receiving a response at a particular stage in the complaints process.

Time Taken to Investigate Complaints

The Prisoner Ombudsman Terms of Reference set a target of 18 weeks from receipt of a complaint to providing a response to the complainant. It is the view of the Prisoner Ombudsman that, in the prison context, this is too long. An internal target now requires complaints to be sent to the Prison Service for a factual accuracy check by 12 weeks (84 days) from the date the complaint was received, in the hope that responses can be given to prisoners more quickly.

There was significant variation in the actual time taken to investigate complaints that were received in 2009/10. This is affected by the seriousness and complexity of the matters involved. In particular, 19 complaints took more than 200 days to investigate and 27 complaints took less than 50 days. If the 19 complaints are excluded, the average time for investigation of all other complaints was 90.8 days.

This is too high and was significantly affected by diverting complaint investigators into Death in Custody investigations. Further efficiencies are being introduced to try and reduce the time taken to complete complaint investigations. However, at the time of going to press, complaints received year to date are well up on 2009/10 and this may, therefore, prove very difficult with existing resources.

Outcome of Complaints Processed

Complaints investigated in 2009/10 resulted in 126 recommendations to the Prison Service. To date a response has been received in respect of 107 of these and 77% of the recommendations have been accepted. Whilst this is significantly lower than the acceptance rate for recommendations made in connection with Death in Custody investigations, it is higher than in previous years and is believed to reflect the effort made to have constructive discussions with Governors about issues emerging from complaints, and to make recommendations that are realistic, achievable, and help to deliver real change.

During the year, the Office reviewed and updated its informal resolution processes to ensure that they are fit for purpose and are used only in circumstances where both parties are entirely happy with the outcome. Complainants are never put in a position where they may be intimidated or pressurised into accepting an outcome that does not resolve their difficulty.

In 2009/2010, 126 recommendations were made by the Office covering a variety of issues.

Recommendations were made about:

... Complaints handling:
- access to the system
- handling of internal complaints

... Purposeful Regime:
- staffing levels
- minimising lock-downs and impact on regime
- gym allocation
- access to education or training

... Prisoners' Property:
- return of goods/property to prisoners
- reimbursement where items have been lost
- better tracking procedures for property
- posting of money to prisoner accounts

... Prisoner Family contacts:
- visits
- mail handling
- tracking processes

... Communication Issues:
- access to Independent Monitoring Board members
- record keeping
- communication between Health Care and Prison Staff

... Rehabilitation:
- movement of prisoners to facilitate rehabilitation
- assessment of risk
- development of appropriate reintegration
- action plans
- sentence planning issues

... Disciplinary Issues:
- arrangements for issuing of adverse reports
- adjudication outcomes
- access to relevant material for prisoners going through the adjudication process.
- the investigation of alleged assaults

... General Prison Conditions:
- heating
- adequacy of standards of hygiene and cleanliness throughout prison
- rights of prisoners to practise their religion
- night lighting systems

... Review of Policies:
- adherence to policies
- home leave
- access to newspapers
- property that is allowed in prison
- smoking in prison
- policy and practise when searching cells
- PREPS regime issues
- searching procedure

Recommendations made by the Prisoner Ombudsman in 2009/2010 have led to changes in a number of areas in the categories above.

In terms of serious assaults, the Prisoner Ombudsman has made recommendations including reminding staff that CCTV footage, telephone and other records must be immediately retained to allow serious incidents or complaints to be properly investigated, and that staff should receive regular training and be assessed annually, as required by Prison Service policy, in their use of control and restraint techniques.

In respect of the late dispatch of letters and other issues relating to internal mail, the Prisoner Ombudsman made a series of recommendations to ensure outgoing mail is promptly dispatched and incoming mail is not held up or damaged, and that prisoners are advised by the Letter Censor's Office if items are confiscated. This has led to a full review taking place at Maghaberry.
Individual recommendations have resulted in specific changes. So, for example, on the recommendation of the Prisoner Ombudsman, all officers and other staff working with life sentence prisoners are receiving training on the conduct of annual reviews.

As a result of another complaint, the Prison Service is taking steps to ensure no prisoner is placed in a cell with another prisoner who is alleged to have made a threat against them, until a risk assessment is carried out. At the same time, there has been a review of the process surrounding risk assessments, with the aim of reducing the length of time they take to complete.

Recommendations from the Prisoner Ombudsman have also led to changes in the arrangements for prisoners held in secure units to attend church services, or request a visit from a chaplain. Prisoners will now receive an explanation if they are refused leave to attend a religious service.

"Prisoners who were visited in prison by a partner or family member have a significantly lower reoffending rate (52%) than those who were not visited (70%)."

Ministry of Justice (2008), Factors linked to reoffending: a one-year follow-up

Provision of Evidence

Brian complained to the Prisoner Ombudsman because he felt the adjudication process that followed a charge against him of disrespectful, threatening and abusive behaviour towards a Prison Officer was not impartial or fairly conducted.

The charge arose from Brian's reaction when he was refused access to the kitchen until it was empty of other prisoners. He believed CCTV tapes of the kitchen area should be made available to demonstrate there were no other prisoners in the kitchen and he should have been let out of his cell earlier. He believed he was not let out because of the Officer's bad mood toward him at that time. Brian said the delay in getting to the kitchen left him feeling frustrated and aggrieved, and that led to an argument with the Prison Officer.

The Prisoner Ombudsman Investigating Officer listened to the tape of the adjudication (which was at that point adjourned pending a decision about the CCTV tapes), and confirmed the Governor carrying out the adjudication did refuse to let the CCTV footage be used.

The Prisoner Ombudsman concluded there was no evidence to suggest there was any breach of impartiality in the conduct of the investigation. However, it was noted that the Prison Service's manual on the Conduct of Adjudications states that in addition to interviews, adjudicators should consider "any other information that is available."

The Ombudsman said that in order to feel justice has been done a prisoner should be able to present any evidence they believe is relevant at an adjudication - in the same way as the Prison Service is able to present all evidence it feels is relevant. It is then for the adjudicating officer to make an appropriate decision based on all of the evidence available.

As a result it was recommended that the relevant CCTV footage should be available to be shown as evidence in Brian's adjudication.

Missing Property

Martin was a talented artist. However, he complained that paintings and handicrafts he had completed in prison were missing after being confiscated from his cell. Requests he made to find the missing items prompted searches by prison staff but the Prisoner Ombudsman was advised that these were fruitless, and although the items should have been handed over to visitors there was no record of this at the Visitors' Reception.

After completing the internal complaints process, Martin's belongings remained lost and he asked the Prisoner Ombudsman to investigate. The Prisoner Ombudsman noted that since Prison Rule 17 (1) states that any property a prisoner is not allowed to retain should be taken into safe custody and is the responsibility of the Governor, Martin should be paid compensation for the missing items. It was not possible to compensate fully for Martin's time and effort, but he should be paid £200 for materials.

Before the Prisoner Ombudsman's report into Martin's case was published, the Prison Governor intervened and carried out a fresh search in which two of the missing paintings were found, though another painting and the handicrafts were still missing.

As a result, the Prisoner Ombudsman recommended that £100, the estimated value, be paid to Martin to compensate for the painting and materials that were still missing.

In addition, new arrangements have been put in place to ensure any paintings and handicrafts that Martin is not allowed to keep in his cell are securely transported to his personal property box.

Reduction in gym allocation

Dennis complained he was only offered two gym sessions per week, while other prisoners were offered up to five sessions.

In response to an internal complaint Dennis was told the difference was due to constraints in escorting prisoners from his house to the gym.

The Prisoner Ombudsman Investigating Officer met Dennis to hear about his complaint and discussed it with prison staff. Dennis suggested the gym schedule should be reorganised to make the allocation of gym sessions fairer to prisoners in his house.

However, staff pointed out to the Investigating Officer that although Dennis was entitled to more sessions under the Earned Privileges Scheme, as a vulnerable prisoner it would not be safe for him to take part in sessions with the general prison population.

In addition, there is some gym equipment in Dennis' house for use during association periods.

The Investigating Officer also studied gym rotas, confirming that sessions are oversubscribed, and this is affecting provision for all prisoners. The Equalities Officer confirmed that the number of sessions Dennis attends is similar to that of other prisoners. Even if Dennis was not classified as vulnerable, he would not be guaranteed any more sessions.

As a result the Prisoner Ombudsman concluded that Dennis was not being treated unfairly. She recommended the Prison Service should continually review gym scheduling, paying particular attention to prisoners who are not getting as many gym sessions as they are entitled to.

Working from home scheme

Ruth was looking forward to commencing her working out placement and then progressing to the working from home scheme.

Following Ruth's release she asked the Prisoner Ombudsman to investigate why she had been informed she was not eligible for the working from home scheme to and clarify what her working from home entitlement should have been.

An Investigator established that in order to bring arrangements for female prisoners into line with those for male prisoners, the rules were changed. As a result, whereas the entitlement for women used to commence six months before release, it is now three months. The Investigator also clarified that to qualify for the working from home scheme, Ruth would have needed to have found paid employment. However, Ruth was not made aware of this, nor had the changes in timing been explained to her.

As a result the Ombudsman recommended that in future any new policy changes should be clearly communicated to prisoners in advance. Where a change adversely affects prisoners caught between old and new arrangements and they have not had a chance to make any adjustments, the old scheme should apply.

Clean Clothing

Jason had been without any of his own clothes, or indeed any clean clothes at all, for 13 days following his committal.

His clothes had been left for him during a committal visit, but despite requests Jason did not receive them until almost 2 weeks later. No emergency clothing was provided, forcing Jason to wear the same clothing for this period.

Following an internal investigation, the Prison Service acknowledged this was unacceptable, agreeing that for personal hygiene reasons emergency clothing should have been provided from prison stock.

Jason asked the Prisoner Ombudsman to investigate the delay in him receiving his own clothes. When the Investigator spoke to prison staff it emerged that a number of factors contributed to the delay, but none of them justified Jason not having clean clothes for two weeks.

As a result new arrangements were agreed for the supply of emergency clothing. The Ombudsman also noted that the provision of emergency clothing should not have been necessary and recommended that the Prison Service examine why this incident occurred, and correct any shortcomings to prevent it happening again.

Adjudication Process

Tracey asked the Prisoner Ombudsman to investigate why she had been treated differently from another prisoner.

Following adjudication Tracey was moved from a landing with enhanced facilities, to another location. Another prisoner who faced an adjudication for the same offence had not been moved.

During the internal complaints process, the Prison Service did note that the decision to move Tracey following her adjudication was perhaps too hasty.

The Prisoner Ombudsman examined the admission criteria to the landing and noted the agreement that prisoners housed there could not have been found guilty of any breach of prison rules. While Tracey had been charged during her adjudication process and subsequently removed from the landing, no formal removal or "de-selection" process was in place at this time. This led to two female prisoners being treated differently when in breach of the admission criteria.

As a result of the investigation a formal de-selection process for the relevant landing was introduced to ensure a more consistent and fairer approach. Tracey also received an apology and she was invited to return to the landing.

Cell search

Mike made an internal complaint when items of property were removed at the time of a body search and cell search.

All the items were things that Mike was permitted to have and he believed they had been taken because he had made a complaint of indecent assault to the police against the officer who carried out the body search.

While coffee and sugar that had been taken from him were subsequently returned to Mike, other items including magazines and newspapers were destroyed.

At this point Mike referred his complaint to the Prisoner Ombudsman, noting staff had admitted taking and destroying the property, and asking for compensation.

The Investigating Officer spoke to staff who dealt with Mike's internal complaint. Each acknowledged that the magazines and newspapers should have been stored in Mike's personal property box, or returned to his family. However Mike was refused compensation on the grounds that because the magazines and newspapers were old, their value was negligible.

As a result the Prisoner Ombudsman concluded that what happened to Mike's property was unacceptable and a breach of prison service policy. It was recommended that the Prison Service reimburse Mike the full cover price of all the items that were destroyed.

Allocation of work

George was unhappy that he had not been given the position of orderly and felt other prisoners were being selected before him because of their religion.

George went through the internal complaints process, through which he was assured there was no religious discrimination. However, George wanted the Prisoner Ombudsman to investigate.

An Investigator met George to discuss his complaint. George gave the example of a returning prisoner on his wing being given an orderly job ahead of him. The Investigator discussed the complaint with prison service staff, including the Equality and Diversity Section.

An in-depth analysis of work allocation was conducted for the period Jan-Jun 2009. The Investigator found that the overall figures for employment within the prison were Roman Catholic 45.21%; Protestant 46.33% other religions 8.57%.

The Prisoner Ombudsman did not find any evidence that the decision made in respect of George involved discrimination on the basis of religious background and therefore did not uphold George's complaint.

APPENDICES

Appendix 1

Terms of Reference for Investigation of Complaints

1. The Prisoner Ombudsman, who is appointed by the Secretary of State for Northern Ireland, is independent of the Northern Ireland Prison Service and reports to the Secretary of State.

2. The Ombudsman will investigate complaints submitted by individual prisoners and ex-prisoners who have failed to obtain satisfaction from the NIPS complaints system and who are eligible in other respects.

3. The Ombudsman will normally act on the basis only of eligible complaints from those individuals described in paragraph 2 (above) and not on those from other individuals or organisations. The Ombudsman will normally act on the basis only of eligible complaints from those individuals described in paragraph 2 (above) and not on those from other individuals or organisations.

4. The Ombudsman will be able to consider the merits of matters complained of as well as the procedures involved.

5. The Ombudsman will be able to investigate all decisions relating to individual prisoners taken by NIPS staff and decisions involving the clinical judgement of Heath Care staff.

6. The Terms of Reference do not cover:
   - policy decisions taken by a Minister[1] and the official advice to Ministers upon which such decisions are based;
   - the merits of decisions taken by Ministers, except in cases which have been approved by Ministers for consideration by the Prisoner Ombudsman;
   - the personal exercise by Ministers of their function in the certification of tariff and the release of mandatory life sentenced prisoners;
   - actions and decisions outside the responsibility of the NIPS such as issues about conviction and sentence; cases currently the subject of civil litigation or criminal proceedings, and the decisions and recommendations of outside bodies such as the judiciary, the police, the Director of Public Prosecutions, the Immigration Service, the Probation Service, the Sentence Review Commissioners, Life Sentence Review Commissioners, Remission of Sentences Commissioners, Loss of Remission Commissioners and their secretariat;
   - actions and decisions taken by contracted-out service providers; and
   - the actions and decisions of people working in prisons but not employed in NIPS[2].

Submitting Complaints and the Limits

7. Before putting a grievance to the Ombudsman, a complainant must first seek redress through appropriate use of the NIPS complaints procedures. Complainants will have confidential access to the Ombudsman and no attempt should be made to prevent a complainant from referring a complaint to the Ombudsman.

8. The Ombudsman will consider complaints for possible investigation if the complainant is dissatisfied with the reply from the NIPS or receives no final reply within six weeks.

9. Complainants submitting their case to the Ombudsman must do so within 30 days of receiving a substantive reply from NIPS. However, the Ombudsman will not normally accept complaints where there has been a delay of more than 12 months between the complainant becoming aware of the relevant facts and submitting their case to the Ombudsman, unless the delay has been the fault of NIPS.

10. Complaints submitted after these deadlines will not normally be eligible. However, the Ombudsman has discretion to consider those where there is good reason for the delay, or where the issues raised are so serious as to override the time factor.

Determining Eligibility of a Complaint

11. The Ombudsman will examine complaints to consider whether they are eligible. To assist in this process, where there is some doubt or dispute as to the eligibility of a complaint, the Ombudsman will inform NIPS of the nature of the complaint and, where necessary, NIPS will then provide the Ombudsman with such documents or other information, as the Ombudsman considers relevant to considering eligibility.

12. The Ombudsman may decide not to accept a complaint or to continue any investigation where it is considered that, the complaint is vexatious or repetitious or frivolous or no worthwhile outcome can be achieved or the complaint raises no substantial issue. The Ombudsman is also free not to accept for investigation more than one complaint from a complainant at any one time unless the matters raised are serious or urgent.

Access to Documents for the Investigation

13. The Director General of the Northern Ireland Prison Service will ensure that the Ombudsman has unfettered access to NIPS documents. This will include classified material and information entrusted to that service by other organisations, provided this is solely for the purpose of investigations within the Ombudsman's terms of reference and subject to the safeguards referred to below for the withholding of information from the complainant and public in some circumstances.

Local Settlement

14. It will be open to the Ombudsman in the course of investigation of a complaint to seek to resolve the matter by local settlement.

Visits and Interviews

15. In conducting an investigation the Ombudsman and staff will be entitled to visit all NIPS establishments, after making arrangements in advance for the purpose of interviewing the complainant, employees and other individuals, and for pursuing other relevant inquiries in connection with investigations within the Ombudsman's Terms of Reference and subject to the safeguards set out below.

Disclosure of Sensitive Information

16. In accordance with the practice applying throughout government departments, the Ombudsman will follow the Government's policy that official information should be made available unless it is clearly not in the public interest to do so. Such circumstances will arise when disclosure is:
   - against the interests of national security;
   - likely to prejudice security measures designed to prevent the escape of particular prisoners or classes of prisoners;
   - likely to prejudice the safety of staff;
   - likely to be detrimental on medical or psychiatric grounds to the mental or physical health of a prisoner or anyone described in paragraph 3 of those terms of reference;
   - likely to prejudice the administration of justice including legal proceedings; or
   - of papers capable of attracting legal professional privilege.

17. NIPS staff providing information should identify any details which they consider needs to be withheld on any of the above named grounds with further check undertaken on receipt of the draft report from the Ombudsman.

Draft Investigation Reports

18. Before issuing a final report on an investigation, the Ombudsman will send a draft to the Director General of NIPS, to allow the Prison Service to draw attention

[1] A personal Ministerial decision is one where the Minister makes a decision either in writing or orally following the receipt of official advice or signs off a letter drafted for their signature.

2 "employed in NIPS" is defined as that contained in section 103 of the Terrorism Act 2000 - this would encapsulate staff in the same prison as the prisoner, other prisons, Headquarters, Prison Officers and other members of the prison staff.

to points of factual inaccuracy, to confidential or sensitive material which it considers ought not to be disclosed, and to allow any identifiable persons subject to criticism an opportunity to make representations.

Recommendations by the Ombudsman

19. Following an investigation all recommendations will be made either to the Secretary of State or the Director General of NIPS, as appropriate, to their roles, duties and powers.

Final Reports Responses to Complaints

20. The Ombudsman will reply to all those whose complaints have been investigated, sending copies to NIPS, and making any recommendations at the same time. The Ombudsman will also inform complainants of the response to any recommendations made.

21. The Ombudsman has a target date to give a substantive reply to the complainant within 18 weeks from accepting the complaint as eligible. Progress reports will be given if this is not possible.

NIPS Responses to Recommendations

22. The NIPS has a target of four weeks to reply to recommendations from the Ombudsman. The Ombudsman should be informed of the reasons for delay when it occurs.

Annual Report

23. The Ombudsman will submit an annual report to the Secretary of State, following the end of the financial year. The report will include:
    - a summary of the number of complaints received and answered, the principal subjects and the office's success in meeting time targets;
    - examples of replies given in anonymous form and examples of recommendations made and of responses;
    - any issues of more general significance arising from individual complaints on which the Ombudsman has approached the NIPS; and
    - a summary of the costs of the office.

Appendix 2

Terms of Reference for Investigation of Deaths in Prison Custody

1. The Prisoner Ombudsman will investigate the circumstances of the deaths of the following categories of person:
    - Prisoners (including persons held in young offender institutions). This includes persons temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It excludes persons released from custody, whether temporarily or permanently. However, the Ombudsman will have discretion to investigate, to the extent appropriate, cases that raise issues about the care provided by the prison.

2. The Ombudsman will act on notification of a death from the Prison Service. The Ombudsman will decide on the extent of investigation required depending on the circumstances of the death. For the purposes of the investigation, the Ombudsman's remit will include all relevant matters for which the Prison Service, is responsible, or would be responsible if not contracted for elsewhere. It will therefore include services commissioned by the Prison Service from outside the public sector.

3. The aims of the Ombudsman's investigation will be to:
    - Establish the circumstances and events surrounding the death, especially as regards management of the individual, but including relevant outside factors.
    - Examine whether any change in operational methods, policy, and practice or management arrangements would help prevent a recurrence.
    - In conjunction with the DHSS & PS, where appropriate, examine relevant health issues and assess clinical care.
    - Provide explanations and insight for the bereaved relatives.
    - Assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are learned.

4. Within that framework, the Ombudsman will set terms of reference for each investigation, which may vary according to the circumstances of the case, and may include other deaths of the categories of person specified in paragraph 1 where a common factor is suggested.

Clinical Issues

5. The Ombudsman will be responsible for investigating clinical issues relevant to the death where the Health Care services are commissioned by the Prison Service. The Ombudsman will obtain clinical advice as necessary, and may make efforts to involve the local Health Care Trust in the investigation, if appropriate. Where the Health Care Trust are commissioned by the DHSS & PS, the DHSS & PS will have the lead responsibility for investigating clinical issues under their existing procedures. The Ombudsman will ensure as far as possible that the Ombudsman's investigation dovetails with that of the DHSS & PS, if appropriate.

Other Investigations

6. Investigation by the police will take precedence over the Ombudsman's investigation. If at any time subsequently the Ombudsman forms the view that a criminal investigation should be undertaken, the Ombudsman will alert the police. If at any time the Ombudsman forms the view that a disciplinary investigation should be undertaken by the Prison Service, the Ombudsman will alert the Prison Service. If at any time findings emerge from the Ombudsman's investigation which the Ombudsman considers require immediate action by the Prison Service, the Ombudsman will alert the Prison Service to those findings.

7. The Ombudsman and the Inspectorate of Prisons will work together to ensure that relevant knowledge and expertise is shared, especially in relation to conditions for prisoners and detainees generally.

Disclosure of Information

8. Information obtained will be disclosed to the extent necessary to fulfil the aims of the investigation and report, including any follow-up of recommendations, unless the Ombudsman considers that it would be unlawful, or that on balance it would be against the public interest to disclose particular information (for example, in exceptional circumstances of the kind listed in the relevant paragraph of the terms of reference for complaints). For that purpose, the Ombudsman will be able to share information with specialist advisors and with other investigating bodies, such as the DHSS & PS and social services. Before the inquest, the Ombudsman will seek the Coroner's advice regarding disclosure. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Reports of Investigations

9. The Ombudsman will produce a written report of each investigation which, following consultation with the Coroner where appropriate, the Ombudsman will send to the Prison Service, the Coroner, the family of the deceased and any other persons identified by the Coroner as properly interested persons. The report may include recommendations to the Prison Service and the responses to those recommendations.

10. The Ombudsman will send a draft of the report in advance to the Prison Service, to allow the Service to respond to recommendations and draw attention to any factual inaccuracies or omissions or material that they consider should not be disclosed, and to allow any identifiable staff subject to criticism an opportunity to make representations. The Ombudsman will have discretion to send a draft of the report, in whole or part, in advance to any of the other parties referred to in paragraph 9.

Review of Reports

11. The Ombudsman will be able to review the report of an investigation, make further enquiries, and issue a further report and recommendations if the Ombudsman considers it necessary to do so in the light of subsequent information or representations, in particular following the inquest. The Ombudsman will send a proposed published report to the parties referred to in paragraph 9, the Inspectorate of Prisons and the Secretary of State for Northern Ireland (or appropriate representative). If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Publication of Reports

12. Taking into account any views of the recipients of the proposed published report regarding publication, and the legal position on data protection and privacy laws, the Ombudsman will publish the report on the Ombudsman's website.

Follow-up of Recommendations

13. The Prison Service will provide the Ombudsman with a response indicating the steps to be taken by the Service within set timeframes to deal with the Ombudsman's recommendations. Where that response has not been included in the Ombudsman's report, the Ombudsman may, after consulting the Service as to its suitability, append it to the report at any stage.

Annual, Other and Special Reports

14. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Secretary of State for Northern Ireland. The Ombudsman may also publish material from published reports in other reports.

15. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Secretary of State for Northern Ireland.

Annex A

Reporting Procedure

1. The Ombudsman completes the investigation.

2. The Ombudsman sends a draft report (including background documents) to the Prison Service.

3. The Service responds within 28 days. The response:
   (a) draws attention to any factual inaccuracies or omissions;
   (b) draws attention to any material the Service consider should not be disclosed;
   (c) includes any comments from identifiable staff criticised in the draft; and
   (d) may include a response to any recommendations in a form suitable for inclusion in the report. (Alternatively, such a response may be provided to the Ombudsman later in the process, within an agreed timeframe.)

4. If the Ombudsman considers it necessary (for example, to check other points of factual accuracy or allow other parties an opportunity to respond to findings), the Ombudsman sends the draft in whole or part to one or more of the other parties. (In some cases that could be done simultaneously with step 2, but the need to get point 3 (b) cleared with the Service first may make a consecutive process preferable.)

5. The Ombudsman completes the report and consults the Coroner (and the police if criminal investigation is ongoing) about any disclosure issues, interested parties, and timing.

6. The Ombudsman sends the report to the Prison Service, the Coroner, the family of the deceased, and any other persons identified by the Coroner as properly interested persons. At this stage, the report will include disclosable background documents.

7. If necessary in the light of any further information or representations (for example, if significant new evidence emerges at the inquest), the Ombudsman may review the report, make further enquiries, and complete a revised report. If necessary, the revised report goes through steps 2, 3 and 4.

8. The Ombudsman issues a proposed published report to the parties at step 6, the Inspectorate of Prisons and the Secretary of State (or appropriate representative). The proposed published report will not include background documents. The proposed published report will be anonymised so as to exclude the names of individuals (although as far as possible with regard to legal obligations of privacy and data protection, job titles and names of establishments will be retained). Other sensitive information in the report may need to be removed or summarised before the report is published. The Ombudsman notifies the recipients of the intention to publish the report on the Ombudsman's website after 28 days, subject to any objections they may make. If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so.

9. The Ombudsman publishes the report on the website. (Hard copies will be available on request.) If objections are made to publication, the Ombudsman will decide whether full, limited or no publication should proceed, seeking legal advice if necessary.

10. Where the Prison Service has produced a response to recommendations which has not been included in the report, the Ombudsman may, after consulting the Service as to its suitability, append that to the report at any stage.

11. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Secretary of State for Northern Ireland. The Ombudsman may also publish material from published reports in other reports.

12. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Secretary of State for Northern Ireland. In that case, steps 8 to 11 may be modified.

13. Any part of the procedure may be modified to take account of the needs of the inquest and of any criminal investigation /proceedings.

14. The Ombudsman will have discretion to modify the procedure to suit the special needs of particular cases.

Photography used is library sourced and representative of prison life scenarios.

Social characteristics of prisoners

Social Exclusion Unit (2002) Reducing reoffending by ex-prisoners, London: Social Exclusion Unit

INFORMATION RELATING TO THE SOCIAL CHARACTERISTICS OF PRISONERS PRESENTS MANY CHALLENGES FOR CRIME PREVENTION AND OFFENDER MANAGEMENT STRATEGIES. IN THE PRISON CONTEXT, THE INFORMATION HAS TO INFORM THE DESIGN OF A PURPOSEFUL, REHABILITATIVE REGIME.

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