The Prisoner Ombudsman for Northern Ireland

REPORT BY THE PRISONER OMBUDSMAN INTO THE CIRCUMSTANCES SURROUNDING THE DEATH IN CUSTODY OF MR JOSEPH ABRAHAM ON 21 APRIL 2012 (AGED 56) WHILST IN THE CUSTODY OF MAGILLIGAN PRISON

[9 May 2013]

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Please note that where applicable, names have been removed to anonynmise the following document

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PREFACE

Mr Joseph Abraham was 56 years old when he died on 21 April 2012, of a heart attack, whilst in the custody of Magilligan Prison.

I offer my condolences to Mr Abraham's family for their sad loss. I met with Mr Abraham's family following his death and met with them again to share the content of this report.

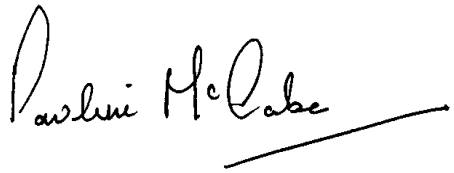
The evidence examined in connection with the investigation into the circumstances of Mr Abraham's death suggests that, overall, he was well cared for at Magilligan and staff were very responsive when he was found in his cell.

As part of the investigation into Mr Abraham's death, Dr Neil Lloyd-Jones, a General Practitioner, was commissioned to carry out a medical review of his healthcare in prison. I am grateful to Dr Lloyd-Jones for his assistance.

In the event that anything else comes to light in connection with the circumstances of Mr Abraham's death, it will be recorded in an addendum to this report and notified to all concerned.

In connection with this investigation, two matters of concern are identified.

I would like to thank all those from the Northern Ireland Prison Service, the South Eastern Health and Social Care Trust and other agencies who assisted with this investigation.



PAULINE MCCABE
Prisoner Ombudsman for Northern Ireland
9 May 2013

INTRODUCTION TO THE INVESTIGATION

Responsibility

1. As Prisoner Ombudsman for Northern Ireland, I have responsibility for investigating the death of Mr Joseph Abraham. My Terms of Reference for investigating deaths in prison custody in Northern Ireland are attached at Annex 1 to this report.

2. My investigation as Prisoner Ombudsman provides enhanced transparency to the investigative process following any death in prison custody and contributes to the investigative obligation under Article 2 of the European Convention on Human Rights.

3. I am independent of the Prison Service, as are my investigators. As required by law the Police Service of Northern Ireland continues to be notified of all deaths in prison.

Objectives

4. The objectives for my investigation into Mr Abraham's death are:

   - To establish the circumstances and events surrounding his death, including the care provided by the Prison Service and relevant outside factors.

   - To examine any relevant healthcare issues and assess the clinical care afforded by the Prison Service and South Eastern Health and Social Care Trust.

   - To examine whether any change in operational methods, policy, and practice management arrangements would help prevent a similar death in future.

- To ensure that Mr Abraham's family have the opportunity to raise any concerns that they may have and that these are taken into account in the investigation and report, and

- To 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.

Family Liaison

5. An important aspect of the role of Prisoner Ombudsman dealing with any death in custody investigation is to liaise with the family.

6. It is important for the investigation to learn more about the person at the centre of the investigation from family members and to listen to any questions or concerns they may have.

7. I first met with Mr Abraham's family on 18 July 2012 and my investigators were grateful for the opportunity to keep in contact with them to provide updates on the progress of the investigation. I met with Mr Abraham's family again on 7 May 2013 to explain and discuss the Findings and Issues of Concern detailed within this report. I would like to thank Mr Abraham's family for giving me the opportunity to talk with them.

8. Mr Abraham's family only raised one matter of concern. They said that they thought that Mr Abraham may have been bullied by an officer and that this may have contributed to his heart attack. I advised Mr Abraham's family that their concern would be fully investigated.

FINDINGS OF THE INVESTIGATION

Mr Joseph Abraham was born on 22 September 1955. He had a strong family history of premature heart disease and was a heavy smoker of 20 cigarettes per day. In October 1997, Mr Abraham suffered a heart attack due to a narrowing of the arteries supplying blood to his heart.

In March 2005, Mr Abraham's general practitioner advised him to have an angiography[1], which Mr Abraham declined as he was *"not experiencing any chest pains."*

In January 2006, Mr Abraham was working as a porter at the local hospital and, whilst pushing a trolley, he experienced chest pain. Mr Abraham was diagnosed with stable angina[2] and was again recommended to have an angiography, which he declined. Over the following months Mr Abraham had regular outpatient reviews and at each visit, he declined to have further invasive investigations.

In September 2007, Mr Abraham was reviewed at a chest clinic and it was noted that he *"remained symptom free"* and that the doctor had *"stressed the importance"* of Mr Abraham's need to stop smoking. Mr Abraham was *"persuaded"* at the review to try atrovastatin (a cholesterol/lipid lowering drug), which he had taken previously but disliked because he had experienced muscle pain and nausea. Records show that Mr Abraham was only issued with this medication on one occasion. At the time of Mr Abraham's follow-up appointment on 26 February 2008, he had already been committed to Maghaberry Prison.

On 19 February 2008, Mr Abraham was committed to Maghaberry Prison and later transferred to Magilligan Prison on 10 July 2008, with an early release date of 18 February 2016.

On committal, Mr Abraham's history of heart problems was noted, as well as his medication of bisoprolol (a type of medication which slows the heart rate),

[1] Angiography is a medical imaging technique which in Mr Abraham's case would have allowed doctors to visualise the inside functioning of his heart.
[2] Angina is a chest pain due to restriction of blood supply to the heart muscle, generally due to obstruction or spasm of the coronary arteries.

amoldipine (which reduces blood pressure in angina sufferers), aspirin and cod liver oil tablets. It was also noted that Mr Abraham was still a heavy smoker and that he had been drinking one litre of brandy every other day, prior to his committal. Mr Abraham did not tell the committal nurse of his ongoing cardiac outpatient reviews nor was there any evidence in his prison medical records that his community medical records were requested.

A review of Mr Abraham's prison medical records does, however, show that there was regular monitoring of his blood pressure, blood tests, cholesterol level and doctor's reviews for his angina.

On 21 October 2011, Mr Abraham was seen by a nurse who noted in his prison medical records that Mr Abraham *"attended for repeat meds, same given, also complaining of jaw pain sometimes when at work. He had angina and does not use GTN spray[3] as it gives him a headache so I advised that he should use the spray for jaw pain and if it relieves it perhaps it is his angina pain and then should see the Doctor. Checked his B/P 120/60 Pulse 60."*

In his clinical review report, Dr Lloyd-Jones said *"I note that there was no follow up to this consultation; basically Mr Abraham did not report the use of his GTN or further pain in his jaw. It is my opinion that the medical care given at this consultation was common and acceptable medical practice."*

It is to note that, in the months following the nursing assessment above, Mr Abraham was seen by healthcare staff on a number of occasions for other medical concerns unrelated to his heart and did not further mention pain in his jaw or any other possible angina symptoms.

Mr Abraham's last doctor's appointment, in relation to his angina, was on 12 January 2012, when he attended for a medication review. Mr Abraham's ongoing heart problems were noted and he was again advised to stop smoking. Mr Abraham's blood pressure and pulse were checked. No complaints of any chest or jaw pain are noted.

[3] GTN Sprays give rapid relief from the pain of an angina attack.

In his clinical review report, Dr Lloyd-Jones said, *"given the nature of this consultation, I would have expected that* (the prison doctor) *would have noted/ read the consultation of 21 October 2011. In conclusion, it is my opinion that this consultation was common and acceptable practice."*

In concluding his review, Dr Lloyd-Jones said, *"I have reviewed all the general practice entries and it is my opinion that the standard of medical care for all complaints, and in particular his heart problem, was common and acceptable medical practice....apart from on 8 July 2008[4], when I feel it would have been common practice to have repeated one particular blood test, that of his CRP[5], but the latter biochemical investigation would not have had any bearing/connection with his cardiological problem."*

In response to Dr Lloyd-Jones' observation that a blood test should have been repeated, the Director of Prison Healthcare from the South Eastern Health and Social Care Trust said *"we are in the process of refining our system in relation to the management of blood results once established, this will address this issue of concern".*

The only concern that was raised by Mr Abraham's family was in relation to the possibility that Mr Abraham had been bullied by an officer and that this may have contributed to his heart attack. Mr Abraham's family said that they thought that Mr Abraham was bullied when he returned to H2 A and B wing, after being moved for three weeks to Sperrin House after he broke the rules of H2 A and B wing. It was alleged that, as a result of being bullied, Mr Abraham spent a lot of his time in his cell *"keeping his head down".*

At the time of Mr Abraham's death he had been working full time, Monday to Friday, in the Stores in Magilligan. One of the officers who worked in the stores said that Mr Abraham never discussed any issues or concerns with him but that he did recall that, when Mr Abraham returned to H2 A and B, he said he was *"much*

[4] On 8 July 2008, Mr Abraham provided blood samples as he was complaining of "*general aches and pains."*

[5] CRP – High sensitivity C-reactive Protein. Whilst measuring CRP in the blood is not specific enough to diagnose a particular disease, it does serve as a general non-specific marker for infection and inflammation which can alert medical professionals that further testing and treatment may be necessary.

happier", because he hadn't enjoyed the dormitory accommodation in Sperrin House.

The investigation listened to Mr Abraham's phone calls. In a telephone call on the day that he returned to H2 A and B wing (2 April 2012), Mr Abraham said that he was *"given the third degree"* by the officer in question but talked about the matter in a light hearted manner. A few days later, on 7 April 2012, Mr Abraham said during another phone call that the officer *"has it in for me".* Between 7 April and 21 April, there are no further references in phone calls to Mr Abraham's treatment by the officer. There is, however, evidence from phone calls that Mr Abraham was *"keeping his head down"* in H2 A and B, because, he said, he was hoping to *"keep his nose clean"* as he wanted to be promoted back to Enhanced[6] status and to be accepted for a move to Foyleview, which has a more relaxed regime and enables prisoners to have jobs in the community.

At interview, one prisoner said that Mr Abraham was being bullied by the officer at the centre of the allegation, whilst another said that this prisoner was *"using"* Mr Abraham's death to *"get his own back"* and *"have a go"* at the officer, who he said, *"ran a tight ship".*

Officers from Mr Abraham's landing who were interviewed said that they were unaware of Mr Abraham being bullied or of him being subdued following his return to H2 A and B wing.

At interview, the officer at the centre of this allegation said *"as far as I am aware Mr Abraham never made any official complaint to myself, to any of my colleagues or through any official channel that I bullied him and any of the times he had arrived on that landing for the two and a half years or three years that he was on that landing".* The officer also said that he had *"exactly the same"* contact with Mr Abraham, when he returned to H2 A and B, as he had had previously and that he *"didn't treat any prisoner down there any differently than anyone else".*

[6] As part of the Progressive Regimes and Earned Privileges Scheme (PREPS), there are three levels of regime - Basic, Standard and Enhanced. The purpose of the PREPS system is to increase participation in constructive activities, encourage good behaviour and thus prepare prisoners for release. This is achieved by rewarding those prisoners who engage positively. An Enhanced prisoner would receive the most privileges including additional visits and increased weekly payments.

The investigation found that Mr Abraham was moved to Sperrin House as a result of an incident where he and another prisoner entered the cell of a third prisoner without permission, to ask him to sign a petition. The petition was instigated after the landing kitchen was closed because one person (an orderly) had left a rubbish bag in it, allegedly by mistake. The kitchen had previously been available to prisoners to use and some prisoners felt that it was unfair that they had all been punished because of the actions of one person. In a complaint investigation, the Prisoner Ombudsman agreed with the prisoners and reminded the management at Magilligan Prison that this was not appropriate or fair.

The prisoner whose cell was entered by Mr Abraham and another prisoner said that he had *"been told by an elder statesman not to get involved as the officers would not like a petition".* An investigation into the incident by the Prison Service established that the prisoner, who entered the cell of the third prisoner with Mr Abraham, had used a plastic knife to gain entry, when the prisoner did not open the door. This was totally unacceptable.

At his adjudication hearing, Mr Abraham said that he was unaware that the cell had been opened in this way. He said *"I went into the cell on the assumption that* (cell occupant – prisoner name redacted) *had opened the cell. If I had known that* (cell occupant - prisoner name redacted) *had not opened the cell, I would not have entered the cell."*

The Prisoner Ombudsman investigation found evidence that, prior to this incident, Mr Abraham was an Enhanced prisoner who would have been considered very trustworthy and who had a very constructive relationship with staff. In light of this, the evidence suggested that Mr Abraham was very upset to have got himself into trouble in connection with this incident. Whilst there is evidence to suggest that an officer may have spoken sternly to Mr Abraham on his return to H2 A and B wing, it is possible that, because of his previous positive relationship with staff, this had a particular impact on him. Either way, there was insufficient evidence to reach any conclusion that Mr Abraham was being bullied by the officer or by anyone else and, as noted above, in the two weeks before his death, Mr Abraham's main objective appeared to be to regain Enhanced status and to be accepted for a move to Foyleview.

On the morning of Mr Abraham's death, on 21 April 2012, CCTV shows that Mr Abraham left his cell at 08.10 to get a cup of tea in the kitchen area, before returning to his cell two minutes later. Mr Abraham never left his cell again.

A letter written by a fellow inmate said *"I was making a cup of coffee in the kitchen of wing A when Joe Abraham came in to make a cup of tea. We exchanged greetings and had a short conversation. Joe made no comment regarding any health issues. I then returned to my cell."*

At 11.50, CCTV shows the food trolley being brought onto the wing for the prisoners to get their lunch.

At 11.58, an officer entered Mr Abraham's cell to let him know that the lunch trolley had arrived. At interview, the officer said that he was aware that Mr Abraham had not come to collect his lunch, so he went to see where he was. The officer said that when he entered Mr Abraham's cell, he was lying on his bed. He said that he placed his hand on Mr Abraham's shoulder to try and get a response and then noticed that Mr Abraham's eyes were *"apparently rolled back"*. Thirty seconds after the officer entered the cell, he can be seen on CCTV shouting down the landing. A colleague responded straight away and ran down the landing into Mr Abraham's cell. A minute later another officer ran to Mr Abraham's cell carrying the defibrillator and, two minutes after that, a nurse entered the cell. A second nurse arrived one minute later.

Accounts from all of the staff in attendance indicate that cardiopulmonary resuscitation (CPR) commenced immediately and that the defibrillator instructed *"no shock"* at all times.

The nurse who responded to the incident first, recorded in Mr Abraham's medical records that:

"Urgent call out by wing staff who found this man in bed and unresponsive. Staff commenced CPR. On arrival of healthcare staff we lifted this man to the floor to aid CPR. Colour blue and cyanosis evident on fingers, toes and lips, skin mottled on appearance. CPR commenced and no signs of life, no pulse evident, CPR continued,

still no signs of life, pupils fixed and dilated. No pulse evident, no shocks recommended or given by CPR machine at any stage throughout the attempted resuscitation....No signs of life evident and healthcare staff decided to discontinue CPR at 12.25pm. Ambulance crew arrived and checked for signs of life ECG showed flat line, no pulse evident."

CCTV shows that the paramedics arrived at 12.32 and left again at 12.43.

At 15.03, a doctor arrived and confirmed Mr Abraham's death at 15.10.

The autopsy report recorded the cause of Mr Abraham's death as *"Coronary Atheroma".*

The pathologist recorded *"death was from natural causes. The coronary arteries of the heart were narrowed* (Atheroma)*, up to a severe degree, by degenerative thickening of their walls and this had reduced the blood supply to the heart muscle and caused some scarring. An acute attack of coronary insufficiency precipitated his death. He was also supposed to have suffered from hypertensive heart disease but at autopsy the heart was not unequivocally enlarged suggesting that his blood pressure was being well controlled.....An analysis for the presence of drugs in the bloodstream was also carried out and this revealed only a therapeutic concentration of the analgesic paracetamol, which had been prescribed for him."*

Responding to the families' concern that Mr Abraham's treatment by an officer may have contributed to the circumstances which resulted in his death, Dr Lloyd-Jones said, *"my area of expertise is that in duty of care and this question in part goes to that of the concept of causation. Therefore if the court decides then the opinion of a cardiologist should be sought. However as a general practitioner it is my opinion, that, on the balance of probability the answer would be no."*

The investigation considered Dr Lloyd-Jones' response to this matter and decided that in light of Mr Abraham's medical history, the findings of the autopsy and the findings of the investigation in respect of Mr Abraham's well-being and demeanour in the period leading up to his death, a cardiologist's opinion was not warranted.

The Self-Harm and Suicide Prevention policy provides guidance on when de-brief meetings should take place following a death in custody. The policy states that *"a cold de-brief will take place within 14 days of the incident to provide opportunities for staff to further reflect on the events surrounding the death in custody and to, perhaps, identify any additional learning from the events".*

The cold de-brief meeting, which was held on 3 May 2012, noted that issues had been raised by staff that *"no aftercare* (was) *offered from management both on the day and on the next tour of duty. Clarification required on management responsibility for aftercare."*

At interview one of the officers who dealt with this incident said *"nobody to this day has actually sat me down….and given me a de-brief as a person and said listen how are you dealing with this?"*

It is to note that, at the time of their Ombudsman interviews, staff were still visibly upset by the memories of Mr Abraham's death. It is regrettable that, once again, the investigation found evidence that staff were not adequately supported.

ISSUES OF CONCERN REQUIRING ACTION

The following issues of concern, requiring action by the Northern Ireland Prison Service and South Eastern Health and Social Care Trust [SEHSCT], were identified during the investigation. I have asked the Director General of the Prison Service and Chief Executive of the SEHSCT to confirm to me that these issues will be addressed.

1. Despite Mr Abraham's medical history, his community medical records were not requested following his committal to Maghaberry Prison, or when he was subsequently transferred to Magilligan Prison.

2. Staff were not supported adequately after Mr Abraham's death and there was evidence that management were not clear about what action they should take to support staff affected by deaths in custody.

RESPONSE TO AREAS OF CONCERN

Northern Ireland Prison Service

In response to the issue of concern regarding the level of support afforded to staff after such an incident, the Director General said:

"The importance of firstly advising staff of the range of support available, and secondly, the proper provision of support and aftercare will be specifically mentioned in the new Managing Serious Self Harm and Deaths in Custody policy which is currently being drafted."

South Eastern Health and Social Care Trust

The South Eastern Health and Social Care Trust have advised that action is being taken to address the issue of concern regarding the accessing of community medical records.

INVESTIGATION METHODOLOGY

Notification

1. On 21 April 2012, the Prisoner Ombudsman's office was notified by the Prison Service about Mr Abraham's death in custody.

2. On 23 April 2012, Notices of Investigation were issued to Prison Service Headquarters and to staff and prisoners at Magilligan Prison, inviting anyone with information relevant to the incident to contact the investigation team.

Prison Records and Interviews

3. All prison records relating to Mr Abraham's period of custody were obtained.

4. Interviews were carried out with prison management, staff and prisoners in order to obtain information about Mr Abraham and the circumstances surrounding this serious incident.

Telephone Calls

5. Between 15 March 2012 and 18 April 2012, Mr Abraham made 31 telephone calls. All 31 telephone calls were obtained and listened to.

CCTV Footage

6. CCTV of H2 A and B wing was obtained and reviewed.

Clinical Review

7. I am grateful to Dr Neil Lloyd-Jones, General Practitioner at Newcastle Medical Centre, who carried out the clinical review.

Factual Accuracy Check

9. I submitted my draft report to the Director of the Northern Ireland Prison Service and the Chief Executive of the SEHSCT for a factual accuracy check.

10. The Prison Service and SEHSCT had no issues with the factual accuracy of this report.

Annex 1

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 healthcare 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 healthcare services 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 Minister for Justice (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 Minister for Justice. 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 Minister for Justice.

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 Minister for Justice (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 Minister for Justice. 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 Minister for Justice. 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.