



The  
**Prisoner  
Ombudsman**  
for Northern Ireland

## **Prisoner Ombudsman for Northern Ireland**

### **Corporate Plan 2009-2012**

### **Annual Business Plan 2009-2010**

## CONTENTS

|  |    |
|--|----|
| <b>Introduction</b> .....                                      | 3  |
| <b>Our Mission</b> .....                                       | 4  |
| <b>Corporate Governance</b> .....                              | 5  |
| Introduction .....   | 5  |
| Management & Accountability .....                              | 5  |
| Corporate Accountability .....                                 | 6  |
| Annual Report .....  | 6  |
| <b>Planning Context 2009-2012</b> .....                        | 7  |
| Planning statements .....                                      | 7  |
| Deaths in Custody .....  | 8  |
| Risk management .....  | 9  |
| Resources .....  | 9  |
| Budget .....   | 10 |
| Organisation .....   | 11 |
| Prisoner Ombudsman Office Values .....                         | 12 |
| <b>Our Strategic Objectives</b> .....                          | 15 |
| <b>Business Plan 2009-2010</b> .....                           | 21 |
| Key Performance Targets (KPT) .....                            | 21 |
| Development Goals (DG) .....                                   | 21 |
| <b>Appendix 1</b> .....  | 26 |
| Terms of Reference for Investigation of Complaints .....       | 26 |
| Terms of Reference for Investigation of Deaths in Prison ..... | 33 |
| <b>Annex A</b> .....   | 38 |
| Reporting Procedure .....                                      | 38 |

## **Corporate Plan 2010-12 and Business Plan 2009-2010**

### ***Introduction***

I am delighted to publish my first Corporate Plan setting out my plans for service delivery and development over the coming three years.

Our vision for the office is to help to ensure that prisons are safe, purposeful places through the provision of an independent, impartial and professional investigation process for complaints and deaths in custody.

Delivering on this vision, in a context of increasing pressure on public funds will be challenging. The future devolution of policing and justice, however, provides a significant opportunity to ensure that the funding allocated to prisons is directed at those aspects of prisoner regime that impact upon reducing re-offending behaviour. This corporate and business plan is designed to ensure that this office adds value going forward and continues year on year to deliver on those objectives which are important to all our stakeholders.

**Pauline McCabe**

**Prisoner Ombudsman for Northern Ireland**

## **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.

## **Corporate Governance**

### ***Introduction***

The Prisoner Ombudsman was established in 2005 and is responsible for the investigation of all complaints from prisoners and, in some circumstances, former prisoners. The Prisoner Ombudsman is also responsible for the investigation of all Deaths in Prison Custody.

### ***Management & Accountability***

The Prisoner Ombudsman, Pauline McCabe, was appointed by the Secretary of State under Section 2(2) of the Prisons Act (Northern Ireland) 1953, as extended by section 2 of the Treatment of Offenders Act (Northern Ireland) 1968. The Prisoner Ombudsman's role is set out within the Prison and Young Offenders Centre (Amendment) Rules (Northern Ireland) 2009.

Further Terms of Reference govern the investigation of eligible complaints and of deaths in custody. Both documents are published on the Prisoner Ombudsman's website [www.niprisonerombudsman.gov.uk](http://www.niprisonerombudsman.gov.uk) and are attached at Appendix 1.

Following the devolution of Policing and Criminal Justice the Prisoner Ombudsman will be accountable to the Northern Ireland Assembly through the Justice Minister for Northern Ireland.

## ***Corporate Accountability***

The Prisoner Ombudsman is an Independent Statutory Office holder for policy and administrative purposes. For Corporate Governance the Prisoner Ombudsman is classified as an Advisory Non-Departmental Public Body.

The Director of Operations is responsible for ensuring that the Prisoner Ombudsman's policies and actions comply with Northern Ireland Office rules and processes and for managing the resources allocated to the office efficiently, effectively and economically.

## ***Annual Report***

The corporate governance of the office by the Northern Ireland Office is carried out through quarterly formal meetings and with an Annual Report made to the Secretary of State, and in the future, post devolution, the Justice Minister after the end of each financial year and published on the Prisoner Ombudsman's website.

## Planning Context 2009-2012

The Corporate plan sets out the Office's direction over the next three years and the vision for achieving our strategic objectives. The Prisoner Ombudsman intends to develop the role of the Office within the Criminal Justice system by achieving the essential milestones, set out below.

### *Planning statements*

- ***Near Deaths*** – A Judgement made in the House of Lords in 2008 determined that, in certain circumstances, “near deaths” in custody should be investigated by an independent body. The investigation of near deaths presents a very important opportunity to promote good practice in care and prevent deaths. The Prisoner Ombudsman would welcome the opportunity, with appropriate resources, to undertake such investigations.
- ***Statutory Footing*** – One of the strategic objectives of the Prisoner Ombudsman's Office is providing an independent and impartial investigation. Without statutory footing, the perception of the independence of, and confidence in the Office, is adversely affected, as is its ability to resource and manage its service delivery in a way that is fit for purpose. It is vital for the Office to be placed on a statutory footing.
- ***Devolution*** - Responsibility for Policing and Criminal Justice is expected to be devolved to the Northern Ireland Assembly in the early phase of this plan. This will present many challenges, not least because of competing funding demands. The Prisoner Ombudsman welcomes the opportunity to demonstrate the efficient service provided by the Office and the value that is brought to the Prison system through having an independent Prisoner Ombudsman.

- **Diversity** - The Northern Ireland Prison population is increasingly diverse and the Prisoner Ombudsman is absolutely committed to providing a service that is respectful of and responsive to everyone's needs. The Prisoner Ombudsman has made significant efforts to address the particular needs of the diverse prison population and will continue to develop services and provide training in order to deliver the best possible service to all within Northern Ireland's prisons.
- **Consultations** – The Prisoner Ombudsman is invited to respond to many consultations in respect of strategies that will impact upon the prison community. It is our policy to respond to any consultation where our experience or working in the Prison Service can add value to the policy document.
- **Complaints Handling** -The Prisoner Ombudsman provides an effective complaints system, in order to help to ensure prisons are safe and purposeful places, where the emphasis is that on rehabilitation and resettlement.

Prisons should be a model of how respectful, law-abiding citizens behave and a good complaints system provides prisoners with an appropriate way of dealing with concerns, problems and frustrations

### ***Deaths in Custody***

The Prisoner Ombudsman investigates all Death in Prison Custody incidents, liaising where necessary with the Police Service of Northern Ireland and the relevant Health & Social Care Trust. A Death in Custody investigation identifies opportunities for building on good practice and for addressing areas of concern. They also provide answers to the questions a family may have after the death of a family member in prison. The Office places particular

emphasis on case conferencing and family liaison as part of the comprehensive investigative process.

The Office continues to play a significant role in supporting the work carried out by the Coroner.

### ***Risk management***

The Prisoner Ombudsman has established a risk management system to identify and assign ownership of risks, to ensure that the strategic objectives and office values are met.

### ***Resources***

The Prisoner Ombudsman is funded by the Northern Ireland Office and the Director of Operations is responsible for making sure that all public funds made available to the Prisoner Ombudsman are used for the purpose intended by Parliament and that such monies, together with the Prisoner Ombudsman's assets, equipment and staff are used economically, efficiently and effectively.

## **Budget**

In 2009/2010 the budget for the Prisoner Ombudsman is:

|                        | <b>2009/2010</b> |
|------------------------|------------------|
| <b>Staff costs</b>     | £379K            |
| <b>Non-staff costs</b> | £309K            |

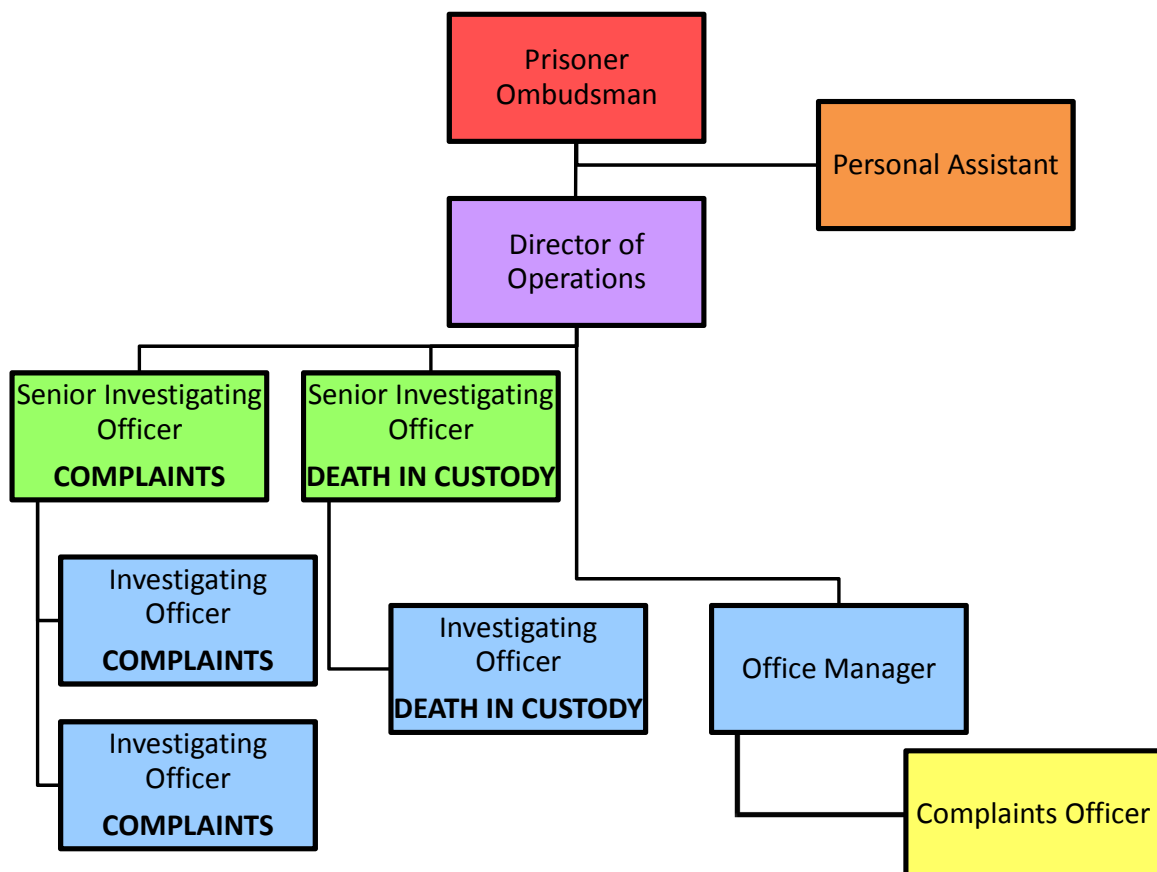
When the Prisoner Ombudsman was asked to investigate Deaths in Prison Custody, no additional staff or funding was provided for this purpose.

The budget above includes additional funding secured to support the investigation of a backlog of Deaths in Custody.

## Organisation

The Prisoner Ombudsman currently employs two Senior Investigating Officers and three Investigating Officers to deal with complaints and Death in Custody investigations, as well as a supporting administration team.

In September 2008, in order to utilise expertise and to focus efforts on a backlog of Death in Custody investigations, the team of staff was divided into a Complaints Team and a Death in Custody Team. It is hoped that the resources needed to make the teams fully functional will be secured as soon as possible and the staff appointed soon thereafter.



## ***Prisoner Ombudsman Office Values***

The Prisoner Ombudsman is committed to providing fair and impartial investigations and a high level of service.

We have chosen to adopt the following principles for the good administration of a complaints system as follows:

### 1. Getting it right

- We will act in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring the leadership to support good internal complaint management and working with the Northern Ireland Prison Service to develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities and ensure lessons are learnt from complaints and deaths in custody investigations.
- Ensuring that staff are trained developed and supported.
- Focusing on the outcomes for the complainant\deceased's family and the Northern Ireland Prison Service.

### 2. Being prisoner focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

3. Being open and accountable
  - Publishing clear, accurate and complete information about how to complain and on the office's death in custody investigation role.
  - Providing staff with comprehensive and robust standards and procedures for handling complaints and deaths in custody.
  - Providing honest, evidence-based explanations and giving reasons for decisions.
  - Keeping full and accurate records.
  
4. Acting fairly and proportionately
  - Treating the complainant impartially, and without unlawful discrimination or prejudice.
  - Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
  - Ensuring that decisions are proportionate, appropriate and fair.
  - Acting fairly towards staff complained about as well as towards complainants.
  
5. Putting things right
  - Acknowledging mistakes and apologising where appropriate.
  - Providing prompt, appropriate and proportionate remedies.
  - Considering all the relevant factors of the case when offering remedies.
  - Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

6. Seeking continued improvement

- Using all feedback and the lessons learnt from complaints\deaths in custody to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from deaths in custody and the implementation of recommendations from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.

## **Our Strategic Objectives**

Over the next three years, we will concentrate on the delivery of our strategic objectives and services in compliance with our Office values.

The six objectives are:

### **Independent**

**To develop and maintain prisoner confidence in the independence and objectiveness of the office of Prisoner Ombudsman**

**By:**

- ◆ Ensuring that all eligible complaints reach the office of Prisoner Ombudsman.
- ◆ Ensuring all correspondence with prisoners and prison staff demonstrates our impartiality and provides evidence of an independent investigation.
- ◆ Ensuring that all ineligible complaints and advice calls are handled thoughtfully and professionally.
- ◆ Highlighting procedural and quality issues in respect of the Internal Complaints Process when reporting on individual complaints.
- ◆ Communicating objectively the role of the office and our achievements through a range of mediums.
- ◆ Carrying out awareness sessions for prisoners and staff and to promote the open accessibility of the office.

## **Professional**

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

**By:**

- ◆ Developing, implementing and reviewing, on an ongoing basis, the methodology for complaint and death in custody investigations in line with best practice.
- ◆ Conducting regular reviews of management information and the outputs of the monitoring system.
- ◆ Ensuring that all necessary resources are in place to support investigations.
- ◆ Developing the application of effective informal resolution processes where appropriate.
- ◆ Working positively with the Northern Ireland Prison Service (NIPS) to improve the way complaints are viewed and treated.
- ◆ Ensuring that all individual performance reviews are conducted.
- ◆ Optimising opportunities for staff training and development.
- ◆ Seeking legal and other professional advice where appropriate during the course of investigations.

## **Efficient**

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

**By:**

- ◆ Ensuring that our telephone answering/administrative systems are effective and demonstrate a high level of service.
- ◆ Ensuring awareness of relevant legislation and policies throughout the office.
- ◆ Monitoring compliance with appropriate legislation and policies.
- ◆ Capturing summary data on eligible complaints, data on non-eligible complaints and problems with the Internal Complaints Process (ICP) and providing this regularly to Governing Governors.
- ◆ Monitoring regularly performance against business plan, expenditure against budget and ensuring that an appropriate risk management framework is in place.
- ◆ Conducting appropriate internal audits and implementing any agreed recommendations.

## **Service**

**To highlight the learning from investigations, to provide an effective and courteous service to all stakeholders; to positively influence the implementation of recommendations that improve service delivery; to answer any family questions about a Death in Custody and to meet the needs of the Coroner**

### **By:**

- ♦ Developing relevant and appropriate recommendations for both complaint and death in custody investigations based on best practice.
- ♦ Fully implementing a tracking system for complaints recommendations using a range of methodologies.
- ♦ Fully implementing improved monitoring arrangements for death in custody recommendations.
- ♦ Publishing all death in custody investigation reports.
- ♦ Publishing summaries of complaint investigations.
- ♦ Providing updates at appropriate intervals to families during death in custody investigations.
- ♦ Maintaining appropriate liaison with key stakeholders to share information and inform decision making.

## **Communication**

**To maximise awareness of the role of the Prisoner Ombudsman with key stakeholders in a changing environment and to keep those to whom we provide a service fully informed about the content and progress of investigations in which they have an interest**

**By:**

- ♦ Ensuring that all stakeholders fully understand the role, outputs and value added by the Prisoner Ombudsman through clear communication of our priorities, principles and activities in all corporate documentation.
- ♦ Sharing information and experience relevant to future discussions on prisons issues, particularly post devolution of policing and justice.
- ♦ Ensuring that all stakeholders are kept up to date on all developments impacting on the operation and the Office.
- ♦ Using a range of mediums to communicate with key stakeholders.

## **Statutory Footing**

**To secure statutory footing and to further develop the role of the Office to meet emerging needs**

**By:**

- ♦ Influencing the timely implementation of statutory footing for the office.
- ♦ Informing future discussions about changes to the role and standing of the office.
- ♦ Developing, implementing and reviewing arrangements for investigating complaints about Probation Services within prison.
- ♦ Developing, implementing and reviewing arrangements for investigating complaints from prisoner visitors
- ♦ Contributing to the development of arrangements for the investigation of “Near Deaths”.
- ♦ Developing, implementing and reviewing protocols for information sharing with other relevant bodies.

## **Business Plan 2009-2010**

**To deliver the strategic objectives set out in the Corporate Plan, key performance targets have been agreed, along with development goals.**

***Key Performance Targets (KPT) - provide quantitative measures in order to determine whether the overall objectives have been reached during 2009/2010.***

***Development Goals (DG) – provide qualitative measures when compared with the overall strategic objectives during 2009/2010.***

### **Independent**

**KPT 1:** To increase visibility and frequency of visits to prison by 30%.

**DG1:** To promote, through the annual report and all other publicity material, confidence in the independence of the Office over the next year.

**DG 2:** To provide assurances and build confidence within the prison population of the independent and impartial role played by the office.

**DG 3:** To produce comprehensive investigative reports which are evidence based and demonstrate objective decision-making.

**DG 4:** To review the impact of the Terms of Reference for Complaints Handling, with regard to Factual Accuracy checking with NIPS, on the perceived independence of the Office.

## **Professional**

**KPT 2:** To ensure an Investigator is on site within four hours of a confirmed Death in Custody.

**KPT 3:** To conduct quarterly reviews of Complaints and DIC manuals for quality assurance.

**KPT 4:** To conduct case conferences of all death in custody investigations every 6 weeks.

**KPT 5:** To organise fortnightly Senior Management Team meetings to discuss relevant operational and strategic issues and planning for future events.

**DG 5:** To provide opportunities for all Investigating Officers to gain accreditation in Investigative methods and other appropriate training identified as necessary to help them achieve their targets.

## **Efficient**

**KPT 6:** To make sure all telephone calls are answered promptly.

**KPT 7:** To ensure all complainants' are interviewed within 4 weeks of their eligible complaint being acknowledged.

**KPT 8:** To provide the Investigation Reports to NIPS for factual accuracy within 12 weeks of an eligible complaint being acknowledged.

**KPT 9:** To provide the Final Investigation Reports to the complainant within 18 weeks of the eligible complaint being acknowledged.

**KPT 10:** To provide the full Death in Custody Investigation Reports to NIPS for factual accuracy within 9 months of date of death.

**KPT 11:** To scrutinise each month's expenditure against budget and monitor any variances.

**KPT 12:** To conduct quarterly reviews of performance against Business plan.

**KPT 13:** To conduct quarterly reviews of Risk Register.

**DG 6:** To provide an efficient and streamlined service for capturing information on complaints, including more robust and comprehensive statistical data.

**DG 7:** To arrange an internal audit review of operational and administration procedures within the Office and to implement any agreed recommendations.

**DG 8:** To maintain and monitor current staffing levels against current workload of Office.

### **Service**

**KPT 14:** To monitor monthly the implementation of complaints' recommendations and conduct any necessary follow up action.

**KPT 15:** To monitor on a quarterly basis, the implementation of actions in relation to recommendations made in DIC investigation reports and request updates from NIPS on progress.

**KPT 16:** To issue a holding letter within ten days of receipt of any correspondence, if a full response cannot be provided before then.

**KPT 17:** To provide updates to families every 8 weeks on the progress of a Death in Custody investigation.

**KPT 18:** To provide supplementary material for all Death in Custody reports to the Coroner as per timeframes agreed in the protocol with the Coroner.

**DG 9:** To develop and implement appropriate procedures for the tracking of recommendations made by the Office.

**DG 10:** To ensure information on recommendations accepted by NIPS, or other Judicial Review decisions, are taken into account in the investigation of new complaints.

**DG 11:** To maintain a high quality of professionalism in all correspondence issued by the office.

### **Communication**

**KPT 19:** To hold awareness raising sessions with prisoners 3 times per annum.

**KPT 20:** To issue three editions of “Inside Issues” magazine to prisoners each year.

**KPT 21:** To produce one Prisoner Ombudsman Annual Report each year

**KPT 22:** To develop and implement a communications approach to raise awareness of the proposed new role of the Office in relation to prison visitor complaints and complaints about Probation.

**DG 12:** To produce a DVD outlining the role of the Prisoner Ombudsman and complaints process to be viewed during prisoners at committal stage.

**DG 13:** To re-design and upgrade the Prisoner Ombudsman website for the provision of timely and comprehensive information to the general public and external stakeholders.

**DG 14:** To monitor press coverage and establish relationships with the media.

**DG 15:** To build on working relationships with Prison Officers Associations within all three prisons.

**DG16:** To develop and implement a communications strategy to help the office achieve its strategic objectives and meet the changing demands of the Criminal Justice System.

**DG 17:** To continue to involve stakeholders in the developing role of the Office.

### **Statutory Footing**

**DG 18:** To continue to meet with Political parties to discuss the importance of the Office achieving statutory footing.

**DG 19:** To develop greater understanding, among key influencers, of the need for the Office to be placed on Statutory footing, including through an effective Communications Strategy.

**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.
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 healthcare staff.
6. The Terms of Reference do not cover:
  - o policy decisions taken by a Minister<sup>1</sup> and the official advice to Ministers upon which such decisions are based:
  - o the merits of decisions taken by Ministers, except in cases which have been approved by Ministers for consideration by the Prisoner Ombudsman;

---

<sup>1</sup> 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.

- 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<sup>2</sup>.

### ***SUBMITTING COMPLAINTS AND TIME 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.

---

<sup>2</sup> “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.

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:
  - o 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 a 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 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 AND 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 12 weeks from accepting the complaint as eligible. Progress reports will be given if this is not possible.

## ***NIPS RESPONSE 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.

## Terms of Reference for Investigation of Deaths in Prison

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 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.
  
16. Annex 'A' contains a more detailed description of the usual reporting procedure.

## **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.