



The
**Prisoner
Ombudsman**
for Northern Ireland

**PRISONER OMBUDSMAN FOR
NORTHERN IRELAND**

ANNUAL REPORT 2013-14



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I am pleased to present my first Annual Report which reflects steady progress, building on the work of previous Ombudsmen Pauline McCabe and Brian Coulter.

The role of the Prisoner Ombudsman is to investigate and report on prisoners' complaints and deaths in custody (DiCs). This work is entirely demand-led, which means volumes are unpredictable. During 2013-14 we commenced investigations into 450 new complaints, four deaths in custody and three post-release deaths. The complaints data represents an 11% increase since last year (the overall average prison population increased by 6% during the same period), suggesting that prisoners and their visitors see the relevance of the office and are prepared to use our services.

The investigations we undertook this year were of varying complexity. They ranged from minor matters that could have been locally resolved, to multiple thematic complaints from Roe House at Maghaberry, where longstanding tensions between prisoners and staff escalated at the beginning of 2014.

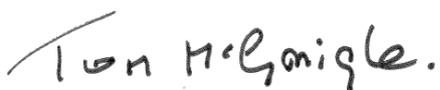
Within this context we worked to undertake impartial and professional investigations which balanced the prisoners' experience with the Northern Ireland Prison Service (NIPS) and South Eastern Health & Social Care Trust (SEHSCT) perspectives. We made 323 recommendations for improvement in relation to complaints, and 90% of these were accepted. However the Prisoner Ombudsman's Office is neither empowered nor resourced to monitor implementation of accepted recommendations, which can sometimes be a source of frustration for prisoners.

Views about the quality of our analysis and findings often depend on the outcome. We welcome feedback, and have amended our practice when useful suggestions have been offered.

We continued to support the prison reform process, working with the NIPS, SEHSCT and Department of Justice (DoJ) to identify and implement changes that can improve prisoners' quality of life and thereby help reduce tensions in the prisons. It is reasonable to anticipate that positive NIPS initiatives - such as intelligence-led searching, reduced handcuffing during transportation, and increased freeflow movement - will lead to a reduced level of complaints.

The launch of a statutory footing consultation for the Office in January 2014 has been an important development. Considerable effort was invested by the DoJ and ourselves to promote awareness of this consultation, and I trust it will contribute to an informed debate about the way forward.

I would like to thank everyone who supported our work throughout the year. I am particularly grateful to all staff in the Prisoner Ombudsman's Office for their contributions to an important public service.



Tom McGonigle
Prisoner Ombudsman for Northern Ireland

July 2014

Background

The Prisoner Ombudsman's Office was set up in 2005 following the Steele review into separated conditions, which suggested establishment of such an office would **“make a valuable contribution to defusing the tensions which are bound to arise in prisons in Northern Ireland.”**

This contribution is fulfilled through two specific functions:

1. Investigate and report on Complaints from prisoners and their visitors; and
2. Investigate and report on Deaths in Custody.

The Prisoner Ombudsman's specific powers regarding investigation of complaints by prisoners, ex-prisoners or visitors to prison establishments are currently set out in the Prison & Young Offender Centre (NI) Rules 2009.

Terms of Reference govern the investigation of complaints and of deaths in custody. They can be found on our website www.niprisonerombudsman.gov.uk. Detailed manuals have been developed to guide staff in their investigations. These are updated as legislation changes.

We adhere to *“The Principles of Good Complaints Handling”* which are Clarity of Purpose, Accessibility, Flexibility, Openness and Transparency, Proportionality, Efficiency, and Quality Outcomes; and we believe that the most productive way to promote improvement is by working in collaboration with the NIPS and SEHSCT, on the basis that we all share the common aim of improvement.

Draft DiC reports are shared with the NIPS, SEHSCT and the next of kin; and final reports are also sent to the Minister of Justice and the Coroners' Office, so that the facts and our analysis and recommendations are shared with those who are directly affected. Our preference is to publish DiC reports in full, in order to serve the public interest. However we must balance the public interest against legal obligations in respect of data protection and privacy, and we take careful account of next of kin views when considering publication. We therefore offer to anonymise reports and redact dates or other identifying information if a report is to be published.

Draft complaint reports are shared with the NIPS and complainants to ensure factual accuracy; and we ask the NIPS to share draft reports with any staff who are criticised. Complaint reports are not published in order to protect the privacy of individuals involved. However summaries are included in the annual report, and in *“Inside Issues”* which is our biannual publication for prisoners.

Mission and Principles

The Prisoner Ombudsman's work is underpinned by a mission statement and six supporting principles:

MISSION STATEMENT

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

Principle 1 - INDEPENDENCE

To maintain and strengthen confidence in the independent and impartial approach of the Office of the Prisoner Ombudsman.

Principle 2 - PROFESSIONALISM

To continuously review and develop investigation processes for Complaints and Deaths in Custody, ensuring high standards of investigative practice, robustness, a proportionate approach and balanced reporting.

Principle 3 - SERVICE-ORIENTATION

To provide an effective and courteous service to all stakeholders and positively influence the implementation of recommendations in order to assist the NIPS and SEHSCT to deliver a purposeful, rehabilitative custodial regime.

Principle 4 - CLEAR COMMUNICATION

To maximise awareness of the role of the Prisoner Ombudsman among key stakeholders, 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.

Principle 5 - EFFICIENCY

To ensure the Office uses its resources efficiently and complies with relevant legislative and governance requirements.

Principle 6 - FORWARD LOOKING

To develop the role of the Office to meet emerging needs.

Organisational Structure and Responsibilities

The first Prisoner Ombudsman for Northern Ireland was appointed in August 2005. The current (third) Prisoner Ombudsman - Tom McGonigle - was appointed by the Minister of Justice on 1st June 2013.

The Prisoner Ombudsman is the head of the organisation and as such, has responsibility for ensuring the Office conducts investigations and reports within its remit. A Director of Operations supports the Ombudsman in the delivery and management of investigations, and deputises for the Ombudsman in his absence. The Director of Operations is also the Chief Executive and Accounting Officer, and therefore has responsibility for day to day running of the organisation.

The Ombudsman and Director of Operations are assisted in their management roles by two Senior Investigators and an Office Manager. The management team receives monthly management reports including updates on current investigations, budget expenditure and staffing.

Corporate Governance

The Prisoner Ombudsman is an “Independent Statutory Office Holder,” currently appointed by the Minister of Justice under section 2(2) of the Prison Act (Northern Ireland) 1953, as extended by section 2 of the Treatment of Offenders Act (Northern Ireland) 1968.

The Prisoner Ombudsman is accountable to the Northern Ireland Assembly through the Minister of Justice, and acts independently of the Prison Service. For corporate governance purposes the Prisoner Ombudsman’s Office is treated as an Advisory Non-Departmental Public Body.

Corporate governance is delivered through quarterly formal meetings with the DoJ sponsoring Division (Reducing Offending Division/ Safer Communities Directorate), at which key corporate documents and processes are reviewed. Financial probity is overseen by DoJ Internal Audit Unit. An Annual Report is prepared after the end of each financial year and published on the Prisoner Ombudsman’s website. The Director of Operations is responsible for ensuring that the Prisoner Ombudsman’s policies and actions comply with DoJ rules and processes, and for managing the resources allocated to the office efficiently, effectively and economically.

Staffing

During 2013-14 the staff complement comprised 11.55 Full Time Equivalent posts/ 13 people:

- Prisoner Ombudsman (4 days pw)
- Director of Operations
- 2 x Senior Investigators (1 @ 30 hrs pw)
- 5 x Investigators; and
- 4 x support staff (2 job-sharing)

The Prisoner Ombudsman is a public appointee, and all other staff are established civil servants. Investigators are selected for their analytical skills and report writing capacity, and training is provided to suit the particular circumstances of the role.

In 2013-14 the average level of staff sickness absence stood at 3.6 days per employee.

Staff Development

A series of team briefing events were held during 2013-14. They included presentations by

- SEHSCT Complaints Manager
- Patient & Client Council
- NI Deputy Commissioner for Complaints
- NIPS Director of Rehabilitation
- NIPS governors
- NI Human Rights Commission

Staff undertook the full range of NICS-required online training during 2013-14. This included data protection, Government security classifications, office safety and fire prevention.

A new Investigator spent several days with the NIPS as part of her induction. This is a practice which we aim to continue.

The Prisoner Ombudsman's Office aims to manage itself according to the best current principles, and to serve as an example of good management practices. The terms and conditions of staff members are those of the Northern Ireland Civil Service (NICS), and the culture of the organisation is modelled on a modern, knowledge-based business. The health and wellbeing of staff members is of paramount concern.

Staff are expected to work beyond conditioned hours when the need arises. That is matched by an on-call allowance, time off in lieu and flexibility in working practices, particularly to meet the needs of those with caring responsibilities.

Staff members are expected to comply with the standards of conduct laid down by in the Civil Service Management Code and in the NICS Standards and Conduct guidance. These set out in detail the rules governing confidentiality, data protection, acceptance of outside appointments and involvement in political activities. Staff members are also expected to adhere to the ethics and principles outlined in the NICS Code of Ethics.

Budget

The 2013-14 operating budget was £690,000, of which 85% was spent on salaries. The Prisoner Ombudsman retained independent legal and public relations advice, and commissioned clinical reviews, transcription and translation services, from within this budget.

Corporate and Business Planning

The Ombudsman's Office worked to existing Corporate and Business Plans during 2013-14. A new Corporate Plan for 2014-17, and a Business Plan for 2014-15 were prepared during the year, consulted with relevant agencies, and published on 31st March 2014.

The Corporate Plan provides a strategic view of developments over the next three years, while the Business Plan for 2014-15 sets out more precisely the objectives, targets and resources we intend to employ to achieve them.



George Richardson, Director of Operations

Statistical Headlines for 2013-14

- **80% of our work came from Maghaberry Prison**
- **We initiated investigations into the deaths of four prisoners, and three ex-prisoners who died within a fortnight of their release**
- **We completed eight DiC investigation reports**
- **Only 7% of all prisoner complaints were escalated to the Ombudsman**
- **We received 450 eligible complaints (an increase of 11% from 2012-13), and completed 468 complaint investigations**
- **We made 323 recommendations for improvement in complaint reports, of which 90% were accepted**

Other Operational Headlines for 2013-14

- **The statutory footing process commenced** with a consultation document to place the office on a statutory footing issued to Justice Committee members on 19th September 2013; and for 12 weeks public consideration on 28th January 2014. We worked closely with the DoJ to encourage interest in the consultation which is important for prisoners and their families, as well as the future of the Prisoner Ombudsman's Office;
- **Prisoners frequently attempted to register complaints about Healthcare** with us. We do not investigate Healthcare complaints, though prisoners' confusion is understandable as we assess the Healthcare dimension of deaths in custody. We continue to work with the SEHSCT and the Patient & Client Council to clarify that aspect of the complaint process for prisoners;
- **Staffing remained relatively stable** for the duration of the 2013-14 year. One Investigator left on promotion within the Northern Ireland Civil Service, and was promptly replaced in October 2013;
- **Longstanding cases consumed a considerable amount of energy and resources.** These included criminal and Coroners court cases, as well as some historic complaints about investigations. In January 2014 the Information Commissioner confirmed that our refusal to disclose a 2009 report to a journalist was appropriate.

Performance against targets 2013-14

We met most key operational objectives such as conducting Complaint and DiC investigations within our remit, and sharing the findings with relevant agencies, prisoners and their families.

The outcomes for measurable objectives in 2013-14 were as follows:

Target	Achieved?	Comment
DiCs – Investigator onsite within four hours	Achieved	
Draft DiC reports provided to the NIPS for factual accuracy not later than nine months from date of the death	Not Achieved	Failure to achieve this objective was due to a backlog from 2011-12, plus eight deaths during 2012-13, when there were significant staff shortages
Complaints – Draft complaint reports to the NIPS for factual accuracy within 15 weeks; and to the complainant within 18 weeks of complaint being acknowledged as eligible	Partially Achieved	80% of drafts went to the NIPS on time; and 63% went to the complainant on time. The difference is explained by delays in receiving NIPS factual accuracy returns
Identify opportunities to reduce the length of time taken to complete complaint and DiC investigations and reports	Achieved	We streamlined the report writing process for both Complaints and DiC reports We also initiated a triage process with the NIPS to resolve certain cases before escalation to us
Operate a tracking system for NIPS confirmation of implementation of accepted recommendations in complaints reports	Partially Achieved	We provided monthly updates to the NIPS. However it was impossible to measure implementation of all accepted recommendations
Ensure families are regularly updated on progress of DiC investigations	Achieved	Families were updated at a minimum of every eight weeks
Secure six monthly updates from NIPS on implementation of recommendations in DiC reports	Partially Achieved	We requested, but did not always secure six monthly updates We monitored implementation of DiC recommendations in subsequent investigations

Target	Achieved?	Comment
Meet regularly with NIPS, SEHSCT, RQIA, IMB, Coroner and other relevant bodies	Achieved	The Prisoner Ombudsman met on a monthly basis with the NIPS Director General; biannually with IMBs and RQIA; and on an ad hoc basis with the Coroners Service and SEHSCT
Review arrangements for investigating complaints about Prisoner Ombudsman services within prisons and agree appropriate next steps	No longer necessary	We did not find it necessary to review arrangements as they appeared to work satisfactorily when invoked
Identify new ways for the NIPS to ensure complaints are dealt with appropriately at local level	Achieved	A triage process was designed and commenced in February 2014 - appropriate cases are referred via NIPS HQ
Issue two editions of "Inside Issues" to prisoners per year	Achieved	
Produce and distribute the annual report	Achieved	
Answer all phone calls within five rings	Achieved	
Monitor monthly expenditure to ensure budget is on target	Achieved	End of year accounts indicate an underspend of less than 2%
Review operating hours of the Freephone service and benefits of multilingual service for foreign national prisoners	Achieved	We concluded the existing hours are suitable to meet current needs

Complaints

We received 11% more eligible complaints in 2013-14 than last year.

Context

Independent investigation of complaints provides an opportunity for prisoners to ventilate their concerns. It is a valuable source of feedback for the NIPS, providing early warning of failures in service delivery. When handled well, complaints can help the Prison Service to improve its service and reputation. Prompt and efficient complaint handling may also save time and money by preventing a complaint from escalating unnecessarily.

An effective complaints system helps instil in prisoners greater confidence that their needs and welfare are being looked after, reducing tension and promoting better relations. A prison is more likely to maintain equilibrium if prisoners feel they have an accessible and effective outlet for their grievances, and confidence that their complaints will be considered properly, with reasons given for decisions.

The NIPS Internal Complaints Process (ICP) is underpinned by prisoners' right to lodge a complaint. While anecdotal evidence suggests that prisoners have mixed views about the effectiveness of the ICP, there would appear to be no general reluctance on the part of the adult male population to submit complaints. NIPS data for the period October 2012 – September 2013 shows:

6,428 complaints, of which:

- 4,947 (80%) were closed at Stage 1
- 1,161 (13%) were closed at Stage 2

There are various reasons for the fall off in complaints at each stage. These range from prisoners receiving a suitable answer, through to being discharged from custody or giving up. Part of the explanation is however a failure to effectively deal with complaints at the first or second stages. This only creates drivers for additional complaints, with a real cost to overall NIPS business.

Prisoners have other means of seeking redress for their grievances: many engage the services of Independent Monitoring Board members who regularly visit the prisons; and 65 Judicial Reviews (JR) were initiated by prisoners against the NIPS between 1st January – 7th October 2013 (average five per month). The main JR themes were refusal of Home Leave or Compassionate Temporary Release, adjudication outcomes, sentence calculation, and internal prison moves.

Figure 1 clearly illustrates how the majority of complaints to our office came from Maghaberry Prison. Table 1 reveals the Maghaberry data was disproportionately high; and also shows that complaint rates from young men in Hydebank Wood were disproportionately low.

Figure 1 - Eligible Complaints by Establishment April 2013 - March 2014

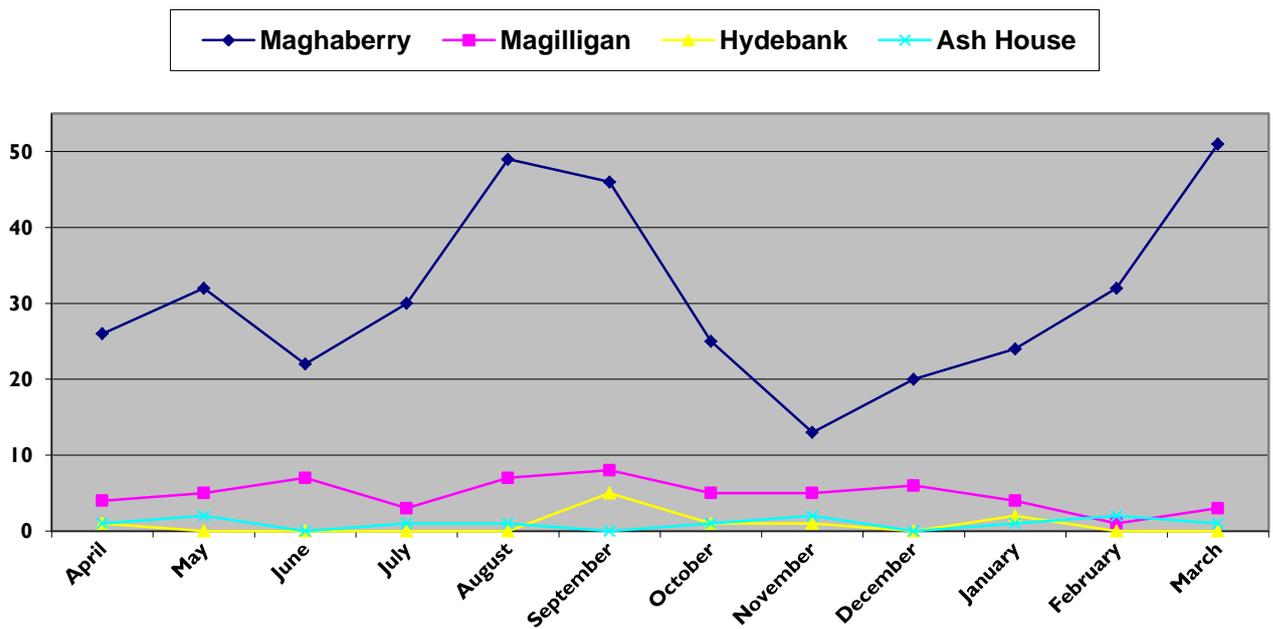


Table 1 – Eligible Complaints Percentages April 2013 – March 2014

Location	Total	Percentage of complaints	Percentage of overall prison population on 31 March 2014	% change since 2012-13
Maghaberry	370*	82%	58%	+19%
Magilligan	58	13%	29%	-11%
Hydebank Wood	9	2%	9%	Not statistically relevant
Ash House	13	3%	4%	
Overall Total	450			

* includes four complaints from visitors

This data has to be set in context: at the end of March 2014 the population had risen by 6% since the same time last year; and there was an upsurge in complaints from separated prisoners in Roe House at the start of 2014.

The 450 eligible complaints were made by 204 individual prisoners. Seven prisoners each made eight or more of these complaints, and their total number of complaints was 82. This represents 3% of complainants accounting for 18% of the eligible caseload.

Table 2 – Maghaberry Eligible Complaints Received by location April 2013 – March 2014

Location	Number of Complaints
Bann	14
Braid	47
Bush	17
CSU	63
Erne	37
Foyle	2
Healthcare	5
Lagan	51
Quoile	34
Released	4
Roe	81
Visitors	4
Wilson	11

Significant points from Table 2 include:

- While the Care & Support Unit generated many complaints, these were often related to events that led to prisoners being housed in the CSU, rather than the time they actually spent there;
- The low complaint rate from Bann House may be explained by its role as the committal house, where most prisoners spent only a short period. Many were in custody for the first time and therefore unfamiliar with the prison complaint system;
- Complaint levels from Quoile House were higher than might be expected, given it is the best accommodation in Maghaberry, which mainly houses selected prisoners;
- Foyle House was closed for refurbishment for most of the year.

Table 3 - Main Complaint Topics 2013-14 and 2012-13

Complaints Topic	2013-14	2012-13
Property and Cash	48	43
Visits	46	24
Staff attitude	46	36
Accommodation	41	7
Adjudications	15	4
Mail	21	7
Searching	21	9
Transfers	19	17
Health & Safety	18	6
Access to regime	15	19
Home leave	15	15
Lock down	14	22
Discrimination	13	16
Education	12	5
Adverse reports	10	4
Miscellaneous	96	163
TOTAL	450	407

Notable points from Table 3 include:

- Property & cash, visits, staff attitudes, and accommodation accounted for most (40%) of the complaints that reached us;
- There were significant increases from the previous year in complaints about adjudications, mail (delays and inappropriate opening of privileged mail), searching, accommodation and visits;
- There were significant reductions in complaints about lockdowns, association curtailment and the tuck shop;
- The reduction in “Other” complaints is accounted for by revised complaints categorisation;
- “Miscellaneous” complaint categories include provision of Offending Behaviour Programmes, night time monitoring of prisoners, Passive Drug Dog indications and work allocation.

We commend NIPS initiatives that have lowered tensions in certain aspects of prison life: NIPS Management Board minutes for January 2014 indicate reduced levels of assaults, use of force and lockdowns. The NIPS suggests that other initiatives - such as a targeted searching policy that was introduced in April 2014 - should help further in addressing prisoners' concerns.

Table 4 - Cleared complaint outcomes April 2013 – March 2014

	Upheld	Not Upheld	Partially Upheld	Local Resolution	Withdrawn	Total
No	216	136	26	58	32	468
%	46%	29%	6%	12%	7%	100%

The “Partially Upheld” category is new, but important in situations where it can be difficult to reach a firm conclusion. “Local Resolution” is a preferred option, and one which we would like to see increase next year.

We made a total of 323 recommendations for improvement during 2013-14. At the time of writing 292 responses had been received from the NIPS, accepting 90% of the recommendations made.

Comparisons

The Prisons & Probation Ombudsman for England & Wales (PPO) upheld 31% of complaints in 2012-13, up from 23% in the previous year.

The Scottish Public Services Ombudsman commented in his 2012-13 Annual Report that prison complaints tend to be relatively straightforward to handle, as it is a matter of confirming the complainant has been treated in conformity with the rules, procedures and policies that govern so much of prisoners' lives. He fully upheld 26.5% of prison complaints in 2012-13, compared with a 46% rate across all other sectors.

Complaint Case Studies

Local Resolution

Mr A complained that he was not kept informed of the progress of a NIPS investigation into a complaint he had lodged. He suggested it was for the Prisoner Ombudsman to share the findings with him as we had received a copy of the NIPS investigation report. However we believed it was for the NIPS to share relevant extracts and conclusions of their report with Mr A. This was done and the complaint was therefore “Locally Resolved.”

Full Body Searching and Data Quality

Four prisoners complained about the extent of random full body searching to which they were subjected, when they were classified as trusted prisoners who complied with all that was asked of them.

The data (from the PRISM IT system) that was given to us by the NIPS indicated the prisoners were not subject to disproportionate levels of full body searching. However the prisoners were able to produce different data, also supplied by the NIPS, which showed higher levels of full body searching.

The NIPS subsequently accepted the data provided to us was flawed, due to human error in inputting. This meant it was impossible for the investigation to reach a definitive conclusion. We raised this as a major concern because it casts doubt on the quality of all such data, which is used for a variety of important purposes.

Compassionate Temporary Release (CTR)

Mr B's complaint was about how his applications for CTR were handled, and lack of bereavement support. Our investigation concluded that Mr B's CTR applications were badly handled.

The NIPS explained CTR decisions had to factor staff safety into their considerations if the prisoner needed to be accompanied, and cited a relevant judicial review that found in their favour. The appropriateness of this point was beyond doubt, but there was a clear pattern of disparate outcomes of CTR applications from prisoners, depending on the religious tradition to which they belonged. This pattern was based on the NIPS PRISM data, which, as indicated above, has proven to be of questionable value in some instances.

We recommended the NIPS should address the disparities; the governor should remind managers and staff who are involved in the CTR application process of the failures in this case; and that support mechanisms should be routinely offered to any prisoner who experiences a family bereavement.

Visits

Three life sentenced prisoners complained about changes to their family visiting arrangements. They were low risk prisoners who had for several years enjoyed a relaxed visits regime, with the opportunity to share meals and interact with family members.

The NIPS considered the relaxed visiting arrangements created serious risks, and were unjustifiable when there was a purpose-built, underused visiting room nearby. It also said several prisoners would soon benefit from moving to the refurbished Prisoner Assessment Unit, where they would have better access to their families. However none of the three prisoners who complained to us was going to meet the eligibility criteria for moving to the PAU for 18 months. Several NIPS staff supported the prisoners' views.

Our investigation concluded the new arrangements represented a retrograde step for the complainants. We recommended a phased response so that they and their families would not be disadvantaged unduly.

The recommendation was not accepted by the NIPS; and one of the prisoners protested by ceasing to take visits.

Phone Access, Diet, Full Body Search and Staff Attitude

Mr C was a foreign national prisoner who spent two days on remand in Maghaberry. He outlined a list of concerns about phone access, diet, full body search and staff attitude. We found that proper procedures were followed in each aspect of his complaint. In some matters there was explicit documentary evidence and/or computer records to disprove his claims. While it was unfortunate that his period in the custody of Maghaberry Prison contributed to distress, his complaints were not upheld.

Window Covering

Mr D's complaint was about the covering on the cell windows in the CSU which obstructed daylight, and also denied him a wider perspective beyond his cell. He was a long term prisoner, held in the CSU for his own protection rather than as a punishment, and felt he should have been accorded a more normal living environment.

The NIPS sympathised with Mr D's predicament, though said it had offered to accommodate him in several other locations. He had refused as he did not feel safe elsewhere. The NIPS explained the protective covering on his cell window was essential in order to protect him from verbal abuse by other prisoners using the yard, onto which his cell faced.

The window covering did indeed reduce the amount of daylight entering Mr D's cell, and we recommended it should be removed, given his long stay and levels of positive interaction with other prisoners in the CSU. The NIPS did not accept this recommendation.

Bullying Investigation

Mr E said he was offered a financial inducement to withdraw a complaint, which alleged governors failed to investigate him being bullied by another prisoner. There was a complex relationship between the victim and the bully.

We found the NIPS had conducted a thorough investigation into all aspects of this longstanding relationship difficulty. In relation to the specific complaint, it was apparent that the governor had actually given Mr E a hardship payment at a time when he had no money to phone his family. We would have been critical if this humanitarian gesture had not been made, and did not uphold the complaint.

Daily Exercise

Mr F complained about not getting an hours exercise in the fresh air. He was refused the exercise on the basis that he had already been out of the house to attend education that day.

We concluded that Mr F's attendance at education had no bearing on his entitlement to an hours exercise in line with Prison Rule 55(1), and recommended all staff should be reminded of prisoners' entitlement to one hours exercise in the open air.

Refurbishment of Ash House

Ms G complained that major structural work in Ash House was proving extremely unpleasant and disruptive to herself and everyone who lived there. The NIPS pointed out that the long term aim was to improve facilities for the prisoners, but accepted the high levels of discomfort entailed in the lengthy refurbishment process. We recommended that the governor should explore options to help improve conditions during the construction work in Ash House.

Healthcare

Mr H made a complaint about inadequate healthcare. He suggested the Prison Service had overall responsibility to ensure prisoners received adequate healthcare.

We clarified that the NIPS does not commission healthcare services for prisoners. Instead healthcare for everyone in Northern Ireland is commissioned by the Health and Social Care Board, irrespective of where they live. In the case of Northern Ireland prisons, the HSCB has commissioned the South Eastern Health and Social Care Trust to deliver healthcare. Therefore complaints about healthcare provision should be referred to the Trust and not to the NIPS.

Offending Behaviour Programmes

Mr I complained that a decision on whether or not he was suitable for the Cognitive Self Change Programme was delayed by over a year. This meant the Parole Commissioners had to adjourn his hearing for six months as he could not present evidence that he had made efforts to reduce his risks.

We found it was unacceptable that the assessment process and commencement of the programme took so long. We recommended the NIPS should provide sufficient resources for the timely assessment of prisoners and subsequent commencement of programmes.

Shortly after this report issued a judicial review found in favour of another prisoner in similar circumstances.

Adjudication

Mr J complained that he had been denied access to a McKenzie Friend in his adjudication. He also said the matter was compounded by the fact that correspondence from his solicitor was not made available to the hearing.

Our investigation upheld his complaint and recommended that NIPS Governors should ensure all adjudicators are familiar with requirements of the Adjudication Manual; and that the complainant should be offered the opportunity for a fresh adjudication with legal representation or attendance of a McKenzie friend.

The NIPS accepted the first recommendation, but rejected the second, essentially on the basis that Mr J had understood the charges fully, and the adjudicating governors had provided sufficient opportunity for him to express his concerns. However the NIPS also developed proposals for appeals against adjudication decisions to be considered at a higher level; and for future Prisoner Ombudsman recommendations about adjudication outcomes to be accepted unless they are procedurally wrong.

The Prisoner Ombudsman initiated investigations into the deaths of four prisoners, and three ex-prisoners who died within a fortnight of their release, as well as completing eight DiC investigations.

Three of the deaths in custody during 2013-14 were of prisoners from Maghaberry Prison and one from Hydebank Wood YOC. One prisoner died in custody and three were either in hospital or in the community at the time of their death, having been released under Prison Rule 27. Two appear to be self-inflicted and two appear to be due to natural causes - the causes are not definitive as Coroner's inquests remain outstanding.

The deaths of the three ex-prisoners (one each from Hydebank Wood, Magilligan and Maghaberry) were reported in March 2014 within a fortnight of their release from custody. At the time of writing, preliminary enquiries are still ongoing. The extent to which these will be investigated depends on the outcomes of post-mortem results and toxicology tests. The key question is whether the deaths were linked to the time these men spent in custody: we will investigate if there is an apparent relationship; and will not investigate if there is no obvious link.

It is important to note that throughout the year we heard of several situations where prisoners almost died in each prison, but were saved by prompt and effective staff intervention.

Between 1st April 2013 – 31st March 2014 we completed eight investigations (seven DiCs and one "Near Death"). Three reports were published during the same period and are available on our website.

We made 99 recommendations for improvement – 69 for the NIPS and 30 for the SEHSCT. The main recommendations involved the process for Supporting Prisoners at Risk (SPAR), anti-bullying procedures, staff support, recording practice, misuse of drugs, medication policy and referrals to support services.

22 of these were recommendations that had previously been made, and accepted, by the NIPS and the SEHSCT. They related to SPAR procedures, staff support, handover procedures, mental health referrals, drugs misuse, obtaining community medical records, referrals to addiction services and first aid training.

We also recognised good practice which included professional medical practice, and support provided to vulnerable prisoners.

On 31st March 2014 we had eight DiC investigations ongoing.

There is a considerable amount of research which provides important learning for deaths in custody: For example prison suicide rates can be reduced significantly, particularly by staff training:

- The number of deaths in England and Wales prisons reduced from 130 per 100,000 prisoners in 2004 to 64 in 2010;
- 107 suicides per 100,000 prisoners in US jails in 1986 reduced to 42 suicides per 100,000 prisoners in 2010

Northern Ireland data is not readily comparable because the scale is so much smaller.

The Ministry of Justice Statistical Bulletin “Safety in Custody Statistics England and Wales - Update to September 2013” provides an important context: *“The mortality rate of the UK prison population is significantly higher than that of the general population. In seven out of the last ten years, prison mortality has been significantly higher than that of the general population.”*

External Communication

The Prisoner Ombudsman maintained a wide range of external communication during 2013-14.

The publication of each DiC report was accompanied by a press release and where appropriate, supplementary communications activity. The Prisoner Ombudsman wrote an opinion piece for the Belfast Telegraph in January 2014 to coincide with launch of the Statutory Footing consultation; and gave media interviews at the time of publishing the 2014-17 Corporate Plan and 2014-15 Business Plan.

He met with the Minister of Justice and local political party justice representatives, with particular emphasis on proposals to place the Office on a statutory footing.

The Prisoner Ombudsman maintained regular contact with relevant bodies during the year. These included the Coroner's Service for Northern Ireland, the Parole Commissioners, Independent Monitoring Boards, the Regulation & Quality Improvement Authority, the Northern Ireland Ombudsman, Criminal Justice Inspectorate, South Eastern Health & Social Care Trust, Prison Officers Association and the Police Ombudsman, and a Joint Secretary of the British-Irish Intergovernmental Secretariat. He also met with the Prisons & Probation Ombudsman in London.

He met monthly with the NIPS Director General, and held quarterly meetings with the governor of each prison.

The Prisoner Ombudsman accepted a number of invitations to address conferences and seminars linked to penal matters. These included talks to NIACRO Prisoners Family Groups, the Quaker Service Annual General Meeting, a Queen's University seminar on Devolution and Penal Policy, a NIACRO Prison Review Followup Seminar. He made presentations, and addressed guests at a Passing Out Parade for Prisoner Escorting and Court Custody Service recruits.

The Prisoner Ombudsman also attended the Independent Monitoring Board annual dinner, and met with the International Committee of the Red Cross. He was a frequent visitor to the prisons, where he met prisoners individually and collectively. He and the Investigators also met with prisoners' families and lobby groups.

In October 2013 the Prisoner Ombudsman and Investigators hosted visiting representatives from Kosovo to discuss civilian oversight of prisons.

"Inside Issues," a four page news sheet, was our main vehicle for communicating with prisoners. It was published as planned, in May and December 2013. The DoJ provided each prisoner with a summary of the Statutory Footing consultation for the Prisoner Ombudsman's Office, and the NIPS placed a full copy of the consultation on every wing of each prison.

Finance

The DoJ Internal Audit Unit Finance & Governance Audit 2013-14 provided a “Satisfactory” level of assurance.

The Prisoner Ombudsman’s Office complies with the Treasury Corporate Code of Governance and with the principles governing relationships between departments and their arms’ length bodies. To this end a Management Statement and Financial Memorandum govern the relationship between the DoJ and the office. It places particular emphasis on:

- The Prisoner Ombudsman’s overall aims, objectives and targets in support of the DoJ’s wider strategic aims, outcomes and targets contained in its current Public Service Agreement (PSA);
- The conditions under which any public funds are paid to the office; and
- How the Prisoner Ombudsman’s Office is held to account for its performance.

As the Prisoner Ombudsman is funded directly from the DoJ programme, rather than by grant-in-aid, its expenditure is recorded as part of the DoJ departmental expenditure. This means the Prisoner Ombudsman does not produce its own set of accounts, nor lay its finances before the Assembly separately from the DoJ.

Consequently financial instruments play a more limited role in creating and managing risk than would apply in a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with expected purchase and usage requirements, and the Office is therefore exposed to little credit, liquidity or market risk.

The Prisoner Ombudsman is committed to the prompt payment of bills for goods and services received in accordance with the Confederation of British Industry’s Prompt Payers Code. During the year ended 31st March 2014, 85% were paid in the 10-day timeframe.

The annual Finance and Governance report by DoJ Internal Audit Unit made three recommendations for improvement – two Priority 3 and one Priority 2.

All proposed business changes are examined through the preparation of a business case. All procurement and contract management processes comply with UK and/or EU procurement regulations to ensure full and fair competition between prospective suppliers; and they are managed in line with Cabinet Office transparency guidelines and approvals processes. The Director of Operations participates in the DoJ Procurement Forum.

Tender evaluation incorporates monetary and non-monetary factors. The Director of Operations reviews the management of supplier performance to ensure that quality and services are maintained for the duration of contracts, and that post evaluation takes place.

Information Security

Information Security is treated as an important priority.

Information Security is managed by the Director of Operations, and the Office is fully aligned with the DoJ Security Policy Framework. This entails quarterly Accreditation and Risk Management reports, annual Security Risk Management Overview returns and participation in the DoJ Information Security Forum and Security Branch.

Staff are trained in, and required to comply with, all NICS security policies and guidance. The Information Security Policy was revised and reissued to staff in September 2013, and a range of other dynamic and static control measures are in place.

Risk Management and Internal Control

A number of risks were re-evaluated during the year and the Risk Register was updated in March 2014 to reflect the highest priorities.

The system of internal control provides a proportionate and reasonable assurance of effectiveness in line with identified risks. The Management Team oversees internal controls and risk management, and reviews their effectiveness. The risk register is an important method of identifying key risks and the means to manage and mitigate them. The register is regularly assessed by the Director of Operations and the Management Team.

Shared Services

An increasing number of corporate services are shared.

- Payroll and Human Resources support have been provided by the DoJ HR Support and the NICS HRConnect service since April 2010;
- Finance transactional support functions have been provided via the Account NI shared service system since July 2012;
- Retained finance functions are provided by Financial Services Division.

The Director of Operations validates expenditure requests, ensures compliance with delegated limits and segregation of duties, and adherence to the Financial Procedures Manual.

Throughout the year the office has checked that its controls and processes are operating effectively, with manual checking of data integrity and accuracy where necessary, specifically in the area of travel and subsistence monitoring and other approvals which lie with the Director of Operations.



The
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Ombudsman**
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