The Prisoner Ombudsman for Northern Ireland

ANNUAL REPORT

April 2008 - March 2009

"My fourth time I messed up so fast I was back in before my friends knew I was out. The other times I did drugs. This time I studied and when I was finished, I studied some more. And once I was released I continued to do the same thing" **Quote from ex-Prisoner to Ombudsman**

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FOREWORD BY THE PRISONER OMBUDSMAN

First, I would like to place on record my appreciation for the work of my predecessor Brian Coulter over the last three years. I took up the post of Prisoner Ombudsman on 1st September 2008, at a time of continuing change within Northern Ireland.

With the early release of prisoners over the past ten years, as a result of the Good Friday/Belfast Agreement, the nature of the prison population has significantly changed. This is prompting a recognition of the need to move on from a primarily security-focussed Prison Service, to one where there is far more emphasis on rehabilitation and reducing re-offending rates.

The sharp increase in the number of foreign national prisoners, from 181 committals in 2006/07, to 291 in 2007/08 and 547 in 2008/09, also brings new challenges.

These changes are in turn changing expectations of the Prison Service, as is reflected, later in this report, the case-studies of the complaints handled by my office.

The change in the prison population is taking place against the backdrop of proposed and actual changes in the Prison Service and in the Criminal Justice System

The 2008 Criminal Justice Order sets out public protection proposals which have far-reaching consequences for the rehabilitation and supervision of prisoners.

In October 2008, responsibility for the delivery of Health Care in prisons in Northern Ireland transferred to the South Eastern Health and Social Services Trust. At the same time, responsibility for complaints concerning Health Care in prison transferred to the Northern Ireland Parliamentary Ombudsman. Throughout this year we worked with the Trust and the Parliamentary Ombudsman to ensure a smooth transition.

An earlier change, in 2005, gave the Prisoner Ombudsman responsibility for investigating Deaths in Custody. When the office was asked to take up this duty no additional resources were provided. With 11 investigations currently in train, the time taken to complete Death in Custody investigations is unacceptable and I am pleased that I have just recently secured some additional resources to assist with this important work.

To support the request for more resources there was a review of the effectiveness and efficiency of our operations. As a result, several changes were made. Most importantly, the team of investigators has been divided into two, one looking after prisoner complaints and the other Death in Custody investigations.

Delays in investigating Deaths in Custody or Prisoner Complaints obviously undermine confidence in the Prisoner Ombudsman. The Office is further undermined by its current lack of independence.

Since taking up my post I have met all of the political parties to discuss the importance of placing the Office on a Statutory Footing. All recognise the need for this to be addressed, and it is my hope this can be resolved as quickly as possible on the heels of the devolution of Policing and Criminal Justice.

I would like to thank colleagues in other parts of the Criminal Justice system for their support during my first year, and to pay tribute to all my team for their tremendous efforts during a period of significant change.

It is fair to say, that this has been a challenging year. However, my overwhelming sense is of just what a privilege it is to do this job.

Pauline McCabe
Prisoner Ombudsman

STATEMENT BY THE PRISONER OMBUDSMAN

Of all the roles of the Prisoner Ombudsman the investigation of Deaths in Custody is the most sensitive. Losing a loved one is sad for any family. Losing a loved one in prison may bring a particular sadness because the family may know so little about what happened in the last hours, days and weeks of their loved one's life.

Wives, husbands, partners and children who have been coping with the absence of someone they love and living for the day of their release, have to face up to the judgement they are not coming home. Illness, drug addiction or mental health problems may have played a role in the death, and inevitably there are questions about the care and support received in prison. And families may have to deal with the fact that their loved one ended his, or her, own life.

Providing an explanation and answering any questions a family may have is an important part of any Death in Custody investigation. Sadly, as in the investigation into the death of Colin Bell, published in January 2009, the information is sometimes not what the family hopes to hear. But invariably, relatives say they prefer to know what happened, regardless of how difficult it might be for them.

Apart from informing the family, Death in Custody investigations fulfil three other important purposes. They assist the Coroner in carrying out his duties, help to ensure the requirements of Article 2 of the European Convention on Human Rights are met, and provide the Prison Service with important information about lessons that can be learned. Recommendations to the Prison Service arising from Death in Custody investigations span a wide range of issues, and concerns have been expressed about the effectiveness and timeliness with which they are implemented. This year I have introduced arrangements asking the Prison Service to provide updates - at appropriate intervals - on progress in implementing recommendations.

The investigation into the death of Colin Bell raised serious issues about the quality of care of vulnerable prisoners and of the need for safer custody arrangements. The Criminal Justice Minister said publicly that he intends "that this tragic death will be a watershed for the Northern Ireland Prison Service". The Minister also put in place measures to progress the action required. The Criminal Justice Inspector will carry out a review of the implementation of the Colin Bell recommendations this summer.

It is important to acknowledge that staff in the Prison Service were dismayed and saddened by the Colin Bell findings. I know that many staff across the Prison Service do their best to perform what can be a very difficult job. During the course of my investigations, I have also come across acts of kindness and thoughtfulness by individual members of staff, in support of prisoners, that go well beyond the requirements of the job.

Health Care in Prisons

In October 2008, responsibility for the delivery of Health Care in prisons in Northern Ireland was transferred to the South Eastern Health and Social Services Trust. At the same time, responsibility for complaints concerning Health Care transferred to the Northern Ireland Parliamentary Ombudsman. We worked closely with the Trust and the Parliamentary Ombudsman to ensure there was a smooth transition and effective communication in areas of overlap and joint concern.

It was agreed with the Parliamentary Ombudsman that responsibility for investigating Health Care issues in Death in Custody cases would remain with the Prisoner Ombudsman. We liaise with colleagues in the Trust, keeping them informed of the progress of investigations and agreeing arrangements for the investigation of issues raised by families relating to external Health Care - for example, concerns about the speed of diagnosis of serious conditions. I believe this arrangement is working well and that it is essential that one organisation has primacy for such investigations. I note the Prisons and Probation Ombudsman for England and Wales has commented on the difficulties arising from shared responsibility for the investigation of Deaths in Custody between his Office and the Health Service.

Investigating Prisoner Complaints

Another major area of work for the Prisoner Ombudsman is the investigation of prisoner complaints. Most people I talk to, even those who would stress the punitive purpose of prison, say the best possible outcome from a prison sentence is that the offender, "does not do it again." In other words, a prisoner's time in prison should be purposeful and provide a model of how respectful, law-abiding citizens behave. Every effort should be made to reduce the likelihood of re-offending.

Prisons can, however, be very closed places where it can be difficult for prisoners to have a voice. An effective complaints system has a crucial role to play in managing frustrations and encouraging acceptable behaviour, by giving prisoners an appropriate model for resolving difficulties and problems.

When I took up the post in September, I noted the number of complaints received by the Office of the Prisoner Ombudsman had declined significantly over the last few years. Whilst this could have been a positive indicator, early research, which included spending time in all of Northern Ireland's prisons and talking to many prisoners and prison staff, persuaded me four key areas of difficulty may have been contributing to the decline in complaints.

Pauline McCabe, Prisoner Ombudsman, speaking at the launch of the Report into the Death of Colin Bell in Maghaberry Prison.

Pauline McCabe, Prisoner Ombudsman, speaking at British and Irish Ombudsman's Association Conference.

These are:

- problems with the operation of the internal complaints procedure, which a prisoner must complete before a complaint can be made to the Prisoner Ombudsman;
- a lack of confidence in the independence of the Ombudsman, resulting from the lack of Statutory Footing of the Office and concerns about the influence of the Prison Service and the NIO on decision-making;
- accessibility - particularly for prisoners with language and/or literacy difficulties; and
- a lack of confidence that recommendations would be implemented by the Prison Service.

Over the last six months a package of confidence-building measures has been put in place and steps taken to improve access to the Prisoner Ombudsman. The most important measure is the introduction of a free-phone service, which means prisoners no longer have to fill out a form, or write a letter, in order to bring a complaint to our attention. Other measures include the introduction of a translation service and of a system for tracking the implementation of recommendations made as a result of complaints investigations. As described later in this report, there has since been a significant increase in the number of complaints received.

Issues concerning the accessibility of the Prison Service's internal complaints process for prisoners who do not speak English, and those who have literacy problems continue to be a cause for concern.

A change in Prison Rules is about to reduce the Internal Complaints Process from three stages to two, a move that will go some way to dealing with the frustration of prisoners who feel the current process is lengthy and unresponsive. Information widely reported to us that prisoners are deterred from complaining and complaints are not always processed, is a cause for concern. Some prisoners believe, for example, that if they complain, they may lose privileges they have earned, family visits may be affected, assessments for work, education or training may be delayed or it will be held against them when a parole application is considered.

I also see examples of officers trying to resolve complaints in a positive and effective way.

Wherever possible, it is in everyone's best interest that problems are dealt with quickly and effectively by staff working with prisoners day to day. In recognition of this, the Prison Service, under the leadership of a specially-designated Governor, is working to improve the handling of internal complaints. We are supporting this in any way we can. In connection with this, we are careful not to take on complaints that are ineligible, and we provide summaries of the reasons given by any prisoners who feel unable to use the Internal Complaints Process, to the relevant Prison Governor. We do, however, make it clear to prisoners calling with complaints we cannot accept, that the complaint has been noted and they can refer it back to the Ombudsman if it is not resolved internally within the time limits.

Something that would be quite trivial in other circumstances may be very important to a prisoner spending many hours each day locked in a cell. This is especially so where a problem relates to letters, phone calls or family visits. Each and every complaint we receive is investigated in a way that is objective, fair and impartial. We take care in notifying a prisoner of our decision to fully explain the reasons. This is a very important element of an effective complaints system, and I am pleased to receive many letters from prisoners including some saying that, whilst they are unhappy with my decision they appreciate that the complaint was fully investigated and the effort made to explain the reasons for the decision. Such feedback is welcome and helpful.

I am currently making arrangements for staff interviewed as part of an investigation to receive copies of decisions reached by my office. It is my hope that the objectivity and fairness evident in the reports will build staff confidence in the way that we do our work and engender belief in the value of effective complaint handling. To this end, I have been pleased also to take part in a number of prison-based staff planning and development workshops and have committed to contribute to all of the Management Development Workshops delivered at the Prison College.

Deaths in Custody

At the time of going to press, my office is currently investigating 11 Deaths in Custody. When the Prisoner Ombudsman was invited by the Director General of the Prison Service to undertake investigations of Deaths in Custody in 2005, no additional resources were provided for carrying out this important work. In this respect, my Office is not fit for purpose and I believe the time it is currently taking to complete Death in Custody investigations is totally unacceptable.

I was pleased to note, at a debate in the Assembly on 23 February 2009, following the publication of the report into the death of Colin Bell, a number of political parties called for the Prisoner Ombudsman to be properly resourced and funded. At the start of this year I prepared a measured business case to secure additional resources to allow us to do our job properly. In the meantime, to help clear the backlog of cases, I have secured the secondment of an investigator from the Police Ombudsman and

engaged a carefully selected external investigator on a contract basis. I am hugely grateful to Al Hutchinson, Sam Pollock and Jim Coupland at the Police Ombudsman's Office for their help in this matter.

At the time of going to press I have been informed that approval has been given for the appointment of one of the additional investigator posts I asked for. I have also been given some of the additional funding I requested on a non-recurring basis.

In support of our request for additional resources we have, in the last six months, undertaken a full review of the operational effectiveness and efficiency of our operation. As a result of this, and building on the work of my predecessor, we have implemented significant changes to the organisation, systems and policy. Our investigators have been divided into two teams, one looking after prisoner complaints, the other Death in Custody investigations. This helps to ensure that both areas of work receive an appropriate level of priority. A comprehensive process for the investigation of Deaths in Custody has also been finalised, with particular emphasis on case conferencing and family liaison. The person specification for Death in Custody investigators has been revised to more adequately reflect the experience and skills required for what can be challenging, multi-faceted investigations. The effectiveness of all these changes is, of course, dependent upon achieving adequate staffing levels.

Staff Training

The training and development of existing staff has also been given priority this year through a number of initiatives. Particularly notable was a workshop where ex-prisoners, and the mother and father of a current prisoner, were invited to share their experiences with staff. At the same workshop all the political parties accepted an invitation to discuss with staff their thoughts on the challenges facing the Prison Service now, and after the devolution of criminal justice, and to consider the role of the Prisoner Ombudsman in that context.

Statutory Footing

Subsequently, I met all of the political parties, to build on these initial exchanges and also to discuss the importance of placing the Office of Prisoner Ombudsman on a Statutory Footing. The need for this was well articulated by Brain Coulter, my predecessor, who resigned from the post because of his extreme concern at a lack of progress in taking this matter forward. At the time of my appointment, the Minister for Criminal Justice gave a commitment to the need for the Office of the Prisoner Ombudsman to have Statutory Footing. However no further progress has been made on achieving this in respect of either Northern Ireland, or England and Wales.

The absence of Statutory Footing impacts upon the actual and perceived independence of the Prisoner Ombudsman, on the ability to adequately meet human rights obligations in respect of investigations, and on ensuring the Office is fit for purpose. In connection with the latter, the requirement to work strictly to all NIO procedures and practices in addressing efficiency and effectiveness issues, and for recruiting staff with appropriate skills, has greatly hindered progress. At the time of writing I have been trying for six months to fill an investigator vacancy arising from a promotion and am still working my way through the process.

I should emphasise that when Statutory Footing is achieved I shall expect and welcome the highest standards of scrutiny and external audit.

Having said the above, I want to thank Brian Grzymek, Head of Criminal Justice Service Division who has been very supportive of me and fought hard to try and secure the resources we need. It is my view however, that these important issues cannot depend upon individual attitudes and personalities and are long overdue being addressed.

There is a broad spectrum of support across the political parties for the Office of the Prisoner Ombudsman to be placed on a Statutory Footing, and I hope that with the devolution of Policing and Criminal Justice this will be resolved as quickly as possible.

The Year Ahead

Looking ahead, a number of developments, which build on progress to date, will be implemented in the next year. A forthcoming change in Prison Rules will allow visitors to raise complaints with the Prisoner Ombudsman. Also, at the time of going to press, a protocol has been signed with the Probation Service, to make provision for the Office to accept, for a pilot period of twelve months, complaints about services delivered by probation officers working in prison. This will apply in circumstances where a prisoner has used the Probation Service Internal Complaints Process but remains unhappy. Both of these very positive initiatives are welcome.

As the result of a decision of the House of Lords in November 2008, the Prison Service is now required

Pauline McCabe, Prisoner Ombudsman, explaining the importance of securing Statutory Footing for the Office to Raymond McCartney, MLA.

Pauline McCabe, Prisoner Ombudsman, discussing the need for the office to be placed on a Statutory Footing with Jeffrey Donaldson, MP MLA.

to ensure there is independent investigation of "near deaths" in prison custody. There is much debate about what constitutes a "near death" and the Prison Service is currently considering how best to respond to this requirement. I believe from the evidence that I have seen, that "near deaths" are important learning opportunities. As many lessons can be learned from a life saved, as from a life lost. Given the synergy between "near death" and Death in Custody investigations, it would seem logical for this important area of work to be undertaken by the Prisoner Ombudsman, and we would be willing to accept this responsibility. Appropriate resourcing commitments would, however, be essential.

Devolution of Criminal Justice

Sometime in the next year responsibility for Policing and Criminal Justice is expected to be devolved to the Northern Ireland Assembly. This will present many challenges, not least because of competing funding demands. The cost of keeping prisoners in prison in Northern Ireland is much greater than in the rest of the United Kingdom and there will undoubtedly be pressures to reduce costs. If, however, there is a desire to move away from a primarily security-focussed Prison Service to one where the emphasis is on education, training, health (and in particular mental health) services, addiction services, vocational training, work experience, resettlement services, and so on, with a view to reducing re-offending rates, there will be the need for a strategic approach. We look forward to sharing knowledge and experience gained through working with prisoners, to help inform decision makers.

In Conclusion

I would like to thank colleagues in other parts of the Criminal Justice system for their support during my first year. I believe, as they do, that effective communication between different parts of the system and the identification of appropriate opportunities for cooperative working are in everyone's interest.

I would like to thank Stephen Shaw, Prisons and Probation Ombudsman for England and Wales who is always so willing to help, advise and share information.

My thanks also to the Prison Service Director General, Prison Governors and all of the prison staff who have helped with investigations and other work during the past year. Finally, I would like to pay tribute to all my team for their tremendous efforts during a period of significant change, and for the thought and care that they put into delivering the service they provide.

Pauline McCabe, Prisoner Ombudsman, speaking at Conference for Members of Independent Monitoring Boards.

PRISONER OMBUDSMAN'S TEAM

Pauline McCabe
Prisoner
Ombudsman

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

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

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

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

Complaints must first have been processed through the Internal Prison Service Complaints System. The Prisoner Ombudsman will take a fresh look at the complaint and decide whether it has been dealt with fairly. If the Ombudsman upholds the complaint, she will make recommendations to the Prison Service to put things right. With effect from 1 September 2005 the remit of the Prisoner Ombudsman was extended, as required by the Secretary of State for Northern Ireland, to carry out Death in Custody Investigations.

Our People

Sinead Simpson
Director of Operations

Michael Hillis
Senior Investigating Officer

Karen McAfee
Investigating Officer Complaints

Pat McKinney
Investigating Officer Complaints

Clare McVeigh
Investigating Officer Deaths in Custody

Paula Curry
Complaints Officer

Sharon Hetherington
Personal Assistant to the Prisoner Ombudsman (P/T)

Linda McIlwrath
Personal Assistant to the Prisoner Ombudsman (P/T)

"Working in the gardens every day gives my head peace, shows me how life could be..."

Quote from Prisoner in Maghaberry prison to Ombudsman

MISSION AND BUSINESS OBJECTIVES

Our Mission

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

Business Objectives

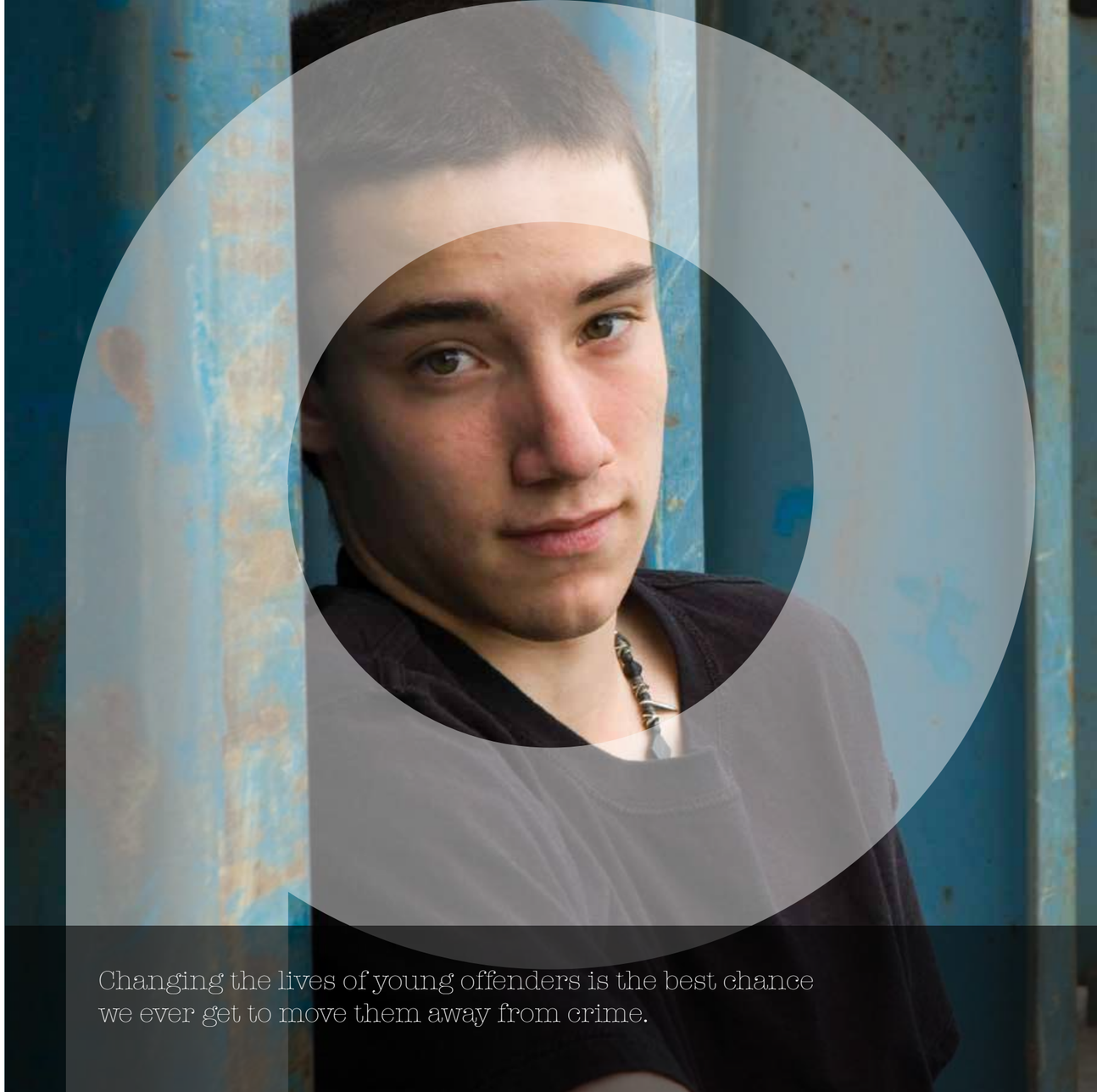
The objectives that the Ombudsman will work towards over the coming years to ensure the mission is achieved will include:

- To develop and maintain prisoner confidence in the independence and objectiveness of the Office;
- To further professionalise the investigation processes for complaints and Death in Custody investigations, ensuring excellence, robustness and a proportionate approach;
- To highlight what has been learnt as a result of our investigations, to positively influence the implementation of recommendations to help improve service delivery, and to answer any family questions about a Death in Custody;
- To maximise awareness of the role of Prisoner Ombudsman with key stakeholders in a changing environment;
- To secure Statutory Footing and further develop the role of the Office to meet emerging needs; and
- To ensure that the Office is efficient and compliant with relevant legislative and governance requirements.

Prisoner Ombudsman Costs 2008/2009

2008/09 Resource Expenditure	£k
Staffing Costs	358
Accommodation Costs	94
Professional Advice	34.2
Other running costs[1]	76.8
Total	**563**

[1] Running costs cover a range of activities including printing of documents, IT costs, training, and staff travel costs.



OUR ACHIEVEMENTS IN 2008/2009...

- Getting it Right
- Being Prisoner Focussed
- Being Open and Accountable
- Acting Fairly and Proportionately
- Putting Things Right
- Seeking Continued Improvement

ACHIEVEMENTS IN 2008/2009

Getting it Right

We introduced arrangements to ensure that all our investigators are either professionally accredited or are working towards accreditation.

- **Our team of investigators has been split into two teams, one responsible for complaints investigations and one for Death in Custody investigations**. This ensures that an appropriate level of priority is given to each of these important work areas.
- **A revised person specification has been developed for Death in Custody investigators** reflecting the need for investigators to be experienced in carrying out complex, multi-faceted investigations.
- **New Death in Custody case management policies, procedures and systems have been developed** and revised case conferencing and family liaison arrangements put in place, to optimise performance, efficiency and quality of delivery. These will be kept under review.
- **New performance management systems have been put in place** to generate timely management information, which is monitored regularly.
- **A strategy for handling the backlog of Death in Custody investigations is being implemented** including a secondment from the Office of the Police Ombudsman and the attachment of a specially-selected independent investigator.
- **A business case has been submitted for the long-overdue appointment of two additional investigators** whose primary area of work will be Death in Custody investigations.
- **All staff are now involved in the development of the aims and objectives of the office,** and have clearly defined personal work objectives that are directly linked to corporate and business objectives.

We work with the Prison Service to help improve the operation of the Internal Complaints Process. We believe that resolving complaints internally is in the best interests of prisoners and prison staff.

Being Prisoner Focussed

We have simplified the way in which prisoners can access the Office through:

- improved access to a free-phone
- a more straight forward complaints leaflet
- clear communication of information about our Office, and how to complain, in "Inside Issues", (the magazine we publish for prisoners every three or four months)
- publishing information about how to contact our office in a range of other languages
- the introduction of a translation service for prisoners who do not speak English.

- **We are preparing posters** (including some designed by prisoners at Hydebank Wood as part of our 2008 Art Competition) that will be posted throughout all prisons that explain the role of the Prisoner Ombudsman and how to use the complaints process.

- **This year we organised a number of prisoner information awareness sessions** at each of the prisons, and will continue to do so.

- **We held a session to inform Chinese speaking prisoners** at Maghaberry Prison of the role of the Prisoner Ombudsman.

- **We have introduced targets for dealing with initial calls from prisoners**, keeping them updated about the progress of complaints and providing a final investigation report.

- **We explain our findings fully and set out the reasons for our conclusions**, whether or not the complaint is upheld.

We work flexibly, seeking, where appropriate, local resolution of a prisoner issue. We are in the process of revising our informal/local resolution processes with a view to ensuring that they are used in a way that is appropriate and helpful.

ACHIEVEMENTS IN 2008/2009

Being Open and Accountable

We have revised all of our corporate documentation to ensure it clearly defines the nature of our business in a user friendly format and shows how we are complying with all relevant legislative and governance requirements.

- **We have redesigned our website to ensure it fully reflects the nature of our business** and is easily accessible. The new site will be launched in Summer 2009.

- **Since September 2008, we publish all Death in Custody investigation reports** and summaries of complaint investigations.

- **We have protocols in place with a number of our stakeholders** including the Northern Ireland Prison Service and the Independent Monitoring Boards, and are currently working to put others in place.

- **Whilst respecting the right to confidentiality of individual complainants we have put in place a policy** of engaging with the media both proactively and reactively to explain the work of the Prisoner Ombudsman, to help achieve better understanding of the issues facing prisoners, and to promote the benefits of making time spent in prison purposeful in order to reduce re-offending rates.

- **We meet with prison officer representatives**, prisoner groups, those who work in and around prisons, as well as others in the wider Criminal Justice System, and also our colleagues in England and Wales, Scotland and in the Republic of Ireland, in order to keep our stakeholders informed about our work and to identify appropriate opportunities for cooperation.

- **We have planned and will soon commence a series of informal "tea-time briefings"** for a range of non-governmental and other prisoner support organisations to explain the work of the office and to further promote opportunities for cooperative working.

In the last few months we participated in an audit of our Death in Custody and complaint investigation processes, and look forward to taking forward any recommendations that may follow.

ACHIEVEMENTS IN 2008/2009

Acting Fairly and Proportionately

We have implemented new systems, policies and procedures for complaint and Death in Custody investigations to ensure that our approach is consistent with best practice and we are always objective, impartial and fair.

- **We work fairly and positively with the Prison Service to help improve how the complaints process** is viewed and treated. We gather data on ineligible complaints, and other advice calls, and share with the Prison Service any information about barriers that are preventing complaints being processed, or undermining confidence in the process.
- **We highlight procedural and quality issues**, identified in dealing with eligible complaints, in order to give staff a fair chance to put things right in the future.
- **We have put in place arrangements to quality assure our investigative work**, through case-conferencing and a review of final reports, to ensure decisions are proportionate and fair.
- **We have put in place the facility for interviews** in Death in Custody investigations, to be recorded, in order that interviewees are assured of total accuracy in capturing information.
- **We are making arrangements for Prison Staff**, who are interviewed in connection with complaints, to see our final reports.

We have agreed with the Prison Officers Association a new procedure for dealing with complaints about members of staff.

ACHIEVEMENTS IN 2008/2009

Putting Things Right

We make recommendations that are constructive, realistic and achievable.

- **We have implemented new arrangements for tracking** the implementation of recommendations arising from complaint investigations, and we go back to inform the prisoner when changes have been made.
- **We meet Prison Service staff and Health Trust staff** to discuss any early findings from Death in Custody investigations, in order that every effort can be made to put things right quickly.
- **We monitor the implementation of any recommendations** made in connection with Death in Custody investigations by asking the Prison Service for progress reports at appropriate intervals.
- **We commission independent, appropriate, clinical advice** on any health issues that may emerge within a Death in Custody investigation and include those findings in the final investigation report. In the past year the list of advisers has been reviewed and extended.
- **We meet Prison Service staff** regularly to highlight any trends or patterns emerging from complaint investigations, or where we see evidence of issues recurring despite previous recommendations.
- **In the past year we have reviewed family liaison arrangements**. We meet, at appropriate intervals, the families of prisoners who have died in custody and keep them informed of the progress of our investigation and developments. We try always to provide answers to their questions.

We provide the Coroner with a copy of all Death in Custody Reports as soon as they are completed and assist the Coroner with enquiries or information requests.

ACHIEVEMENTS IN 2008/2009

Seeking Continued Improvement

We have in recent months visited prisons outside of Northern Ireland to help ensure our recommendations are based on best practice.

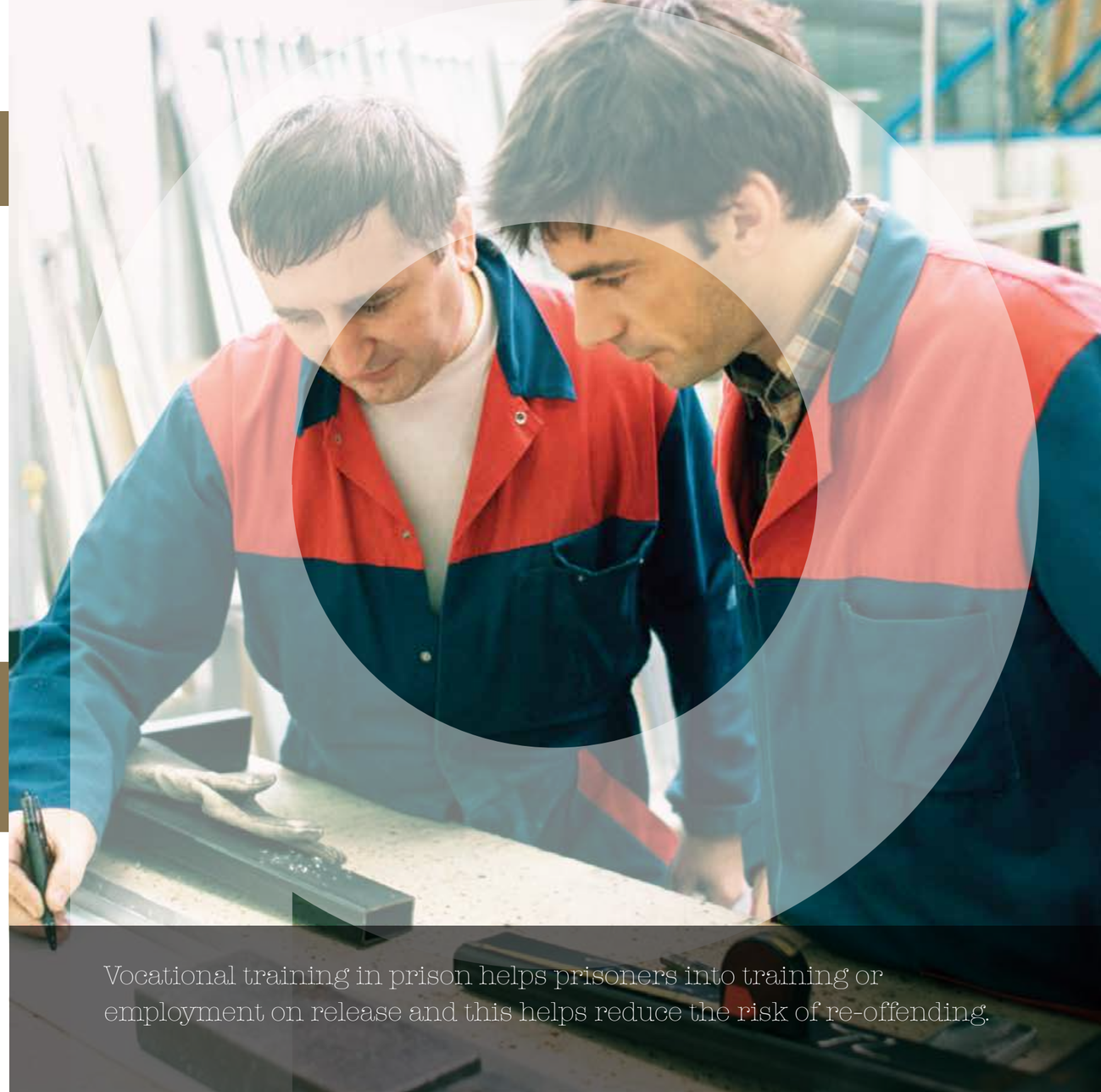
- **We highlight in Death in Custody reports any strategic and wider or systemic issues** that need to be addressed. Examples of this were seen in the report of the investigation into the death of Colin Bell, which addressed a wide range of issues relating to the management of vulnerable prisoners and safer custody arrangements.

- **We use our experience and knowledge of prisons issues** to inform policy development:
  - **We have responded to the consultative exercise** for the development of a strategy for the management of women offenders in Northern Ireland.
  - **We will, in the near future, respond to consultations on revised Prison Rules** and Gender Specific Standards for Women Prisoners.

- **We share our knowledge and experience with relevant decision-makers** including most recently, all of the main political parties in the Northern Ireland Assembly, in the hope that this may assist in decision-making about prisons issues.

- **We are contributing to the development of an effective response to the recent House of Lords judgement** which declared that there should be independent investigation of "near deaths" in prison custody. We firmly believe that the investigation of "near deaths" provides a significant opportunity for learning that could prevent deaths in custody.

We have introduced a programme of regular meetings with the Chairs of the Independent Monitoring Boards to share information so that we can cooperate effectively when delivering our different but complementary responsibilities.



Vocational training in prison helps prisoners into training or employment on release and this helps reduce the risk of re-offending.

COMPLAINTS HANDLING

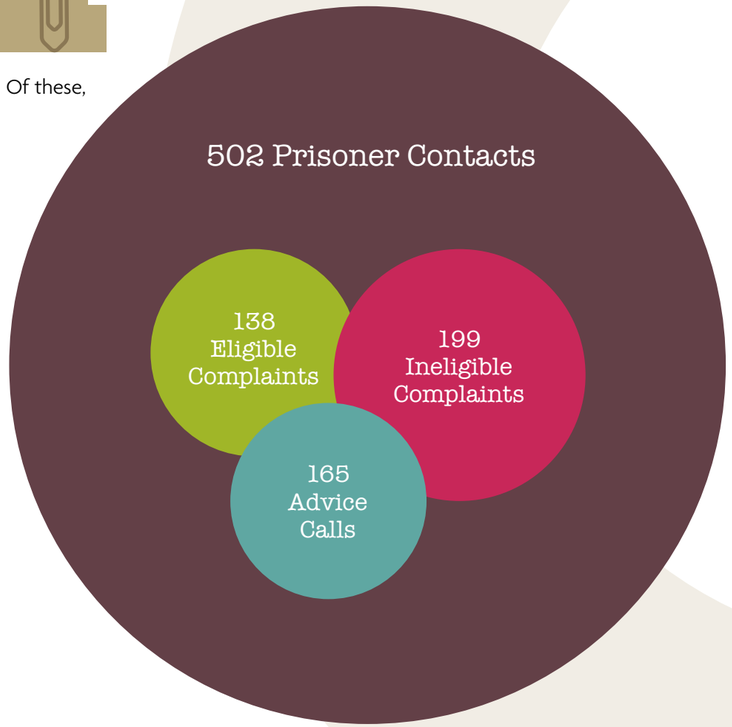
Overview

The Prisoner Ombudsman investigates complaints submitted by individual prisoners and ex-prisoners who have failed to resolve the problem or concern through the Prison Service Internal Complaints Process.

Complaints Received

337 complaints were received in 2008/2009. Of these, 138 were eligible and 199 were ineligible.

Figure 1. Prisoner Complaints



Complaints Processed

Of the 337 complaints received in 2008/2009, 165 were concluded within the year with the remainder carried over to 2009/2010. The Office also dealt with 107 complaints that had been carried forward from 2007/2008. Investigations into 272 cases were, therefore, concluded in 2008/2009.

Ineligible Complaints

It is often not immediately clear that a complaint is ineligible. Further exploration is required involving contact with the prisoner or with Prison Service staff on the landing, or examination of relevant rules, legislation or policy. Most of the ineligible complaints are deemed ineligible because they have not completed the three stages of the Internal Complaints Process.

Advice Calls

In the last 12 months 165 advice calls were received. Some of these are relatively easy to deal with, others less so. These calls can be from prisoners who require some assistance with an issue or concern and are not sure with whom they should raise it. Calls can also be from relatives of prisoners who are concerned for the welfare of their father, mother, brother, son or daughter. They may include concerns about self-harming that require immediate and appropriate action to be taken.

EST = Estimated

Figure 2. Complaints Statistics

	05/06	06/07	07/08	08/09
Total Complaints Received	**368 (225 est)**	**252 (246 est)**	**207 (246 est)**	**337 (139 est)**
Complaints received by Establishment				
Maghaberry	289 (78.4%)	202 (80.1%)	130 (62.8%)	213 (63%)
Magilligan	66 (17.8%)	41 (16.3%)	27 (13%)	98 (29%)
Hydebank Wood Female	6 (1.5%)	6 (2.4%)	44 (21.2%)	21 (6%)
Hydebank Wood YOC	7 (2.3%)	3 (1.2%)	6 (3%)	5 (2%)

Origin of Complaints

As can be seen from Figure 2. above, over 60% of all complaints come from Maghaberry Prison. This is in part a reflection of the greater prison population at Maghaberry, which is the main committal prison in Northern Ireland and also has a mix of different security classifications. Maghaberry Prison houses all Category A [High Risk] prisoners and the management of the regime within the prison is, to a large extent, currently determined by this. 29% of complaints were received from Magilligan prison, 6% from Hydebank Wood (Female) and 2% from Hydebank Wood YOC.

Extremely few complaints have been received by the Prisoner Ombudsman from male young offenders and juveniles at Hydebank Wood over the years. Steps are currently being taken to explore why this is the case, through prisoner information sessions and at meetings with staff and management.

Whilst a low number of complaints can be a very positive indicator, it is also well documented that barriers to accessing a complaints process can be more acute for young people. We hope to work positively with Hydebank Wood to gain a greater understanding of both positive factors and concerns impacting upon the level of complaints.

The relatively high number of complaints from female prisoners at Hydebank Wood is distorted by a large number of complaints from a few female prisoners. Again, there is evidence that female prisoners may have particular problems with, or concerns about, accessing complaints processes. Working with staff at Hydebank Wood to identify and address any relevant issues is a priority for the next 12 months.

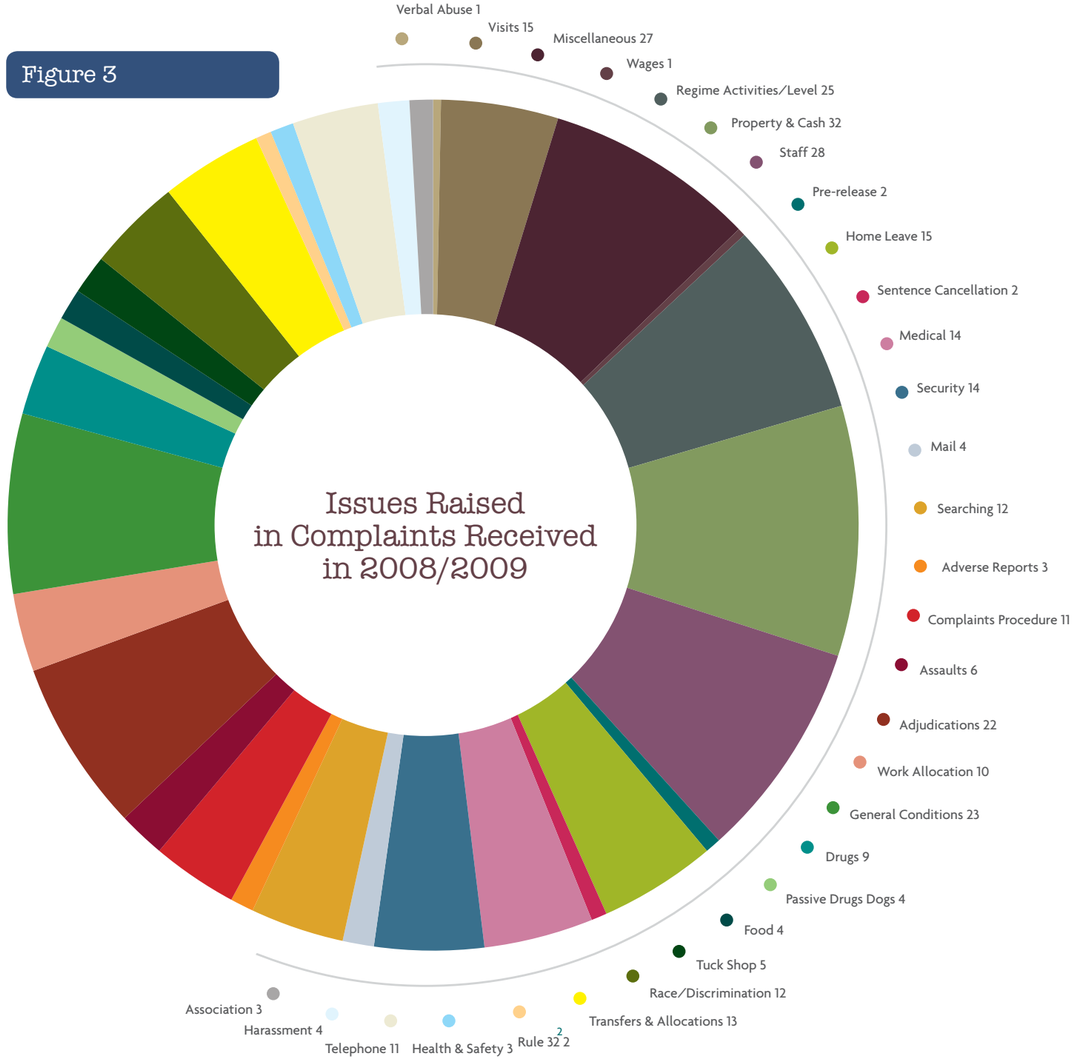
Issues raised in complaints

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

This year has seen a new category of complaint emerge around race issues and discrimination, and other issues which have a particular impact on foreign national prisoners. This may well be a reflection of the changing face of the prisoner population and the increasing numbers of foreign national prisoners. While the overall proportion of complaints from foreign national prisoners is low, there may be particular difficulty, because of language, in accessing the complaints process. The Prison Service and the Prisoner Ombudsman are endeavouring to address this.

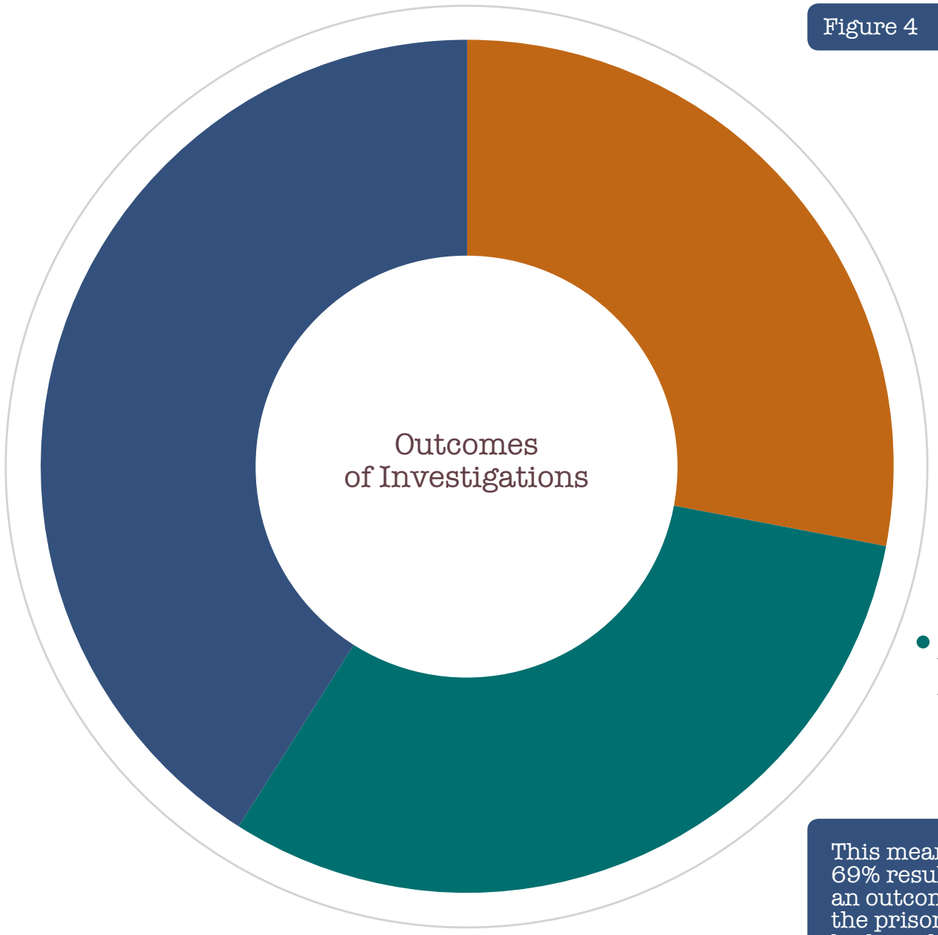
Prisoner Ombudsman publications have information in other languages to inform foreign national prisoners about the complaints process. When a contact is received from a foreign national prisoner, a translator is sent with the Prisoner Ombudsman Investigator to meet the prisoner.

Figure 3



[2] Rule 32 provides for the restriction of a prisoner's association where it is deemed necessary for the maintenance of good order or discipline, or in their own interests.

Figure 4



- Just over 41% [77] were resolved through local resolution and again in 8 cases recommendations were made.
- 28% [53] were upheld with recommendations made in each
- just over 31% [59] were not upheld but while they were not upheld, recommendations were made in six cases

This means that 69% resulted in an outcome that the prisoner felt had resolved their problem or concern in an appropriate way.

Outcome of Complaint Investigations

Of the 272 cases investigated in 2008/2009, 73 were ineligible complaints and 10 were later withdrawn.

As can be seen from Figure 4, nearly 70% of the remaining 189 eligible complaints investigations were upheld or resulted in the problem being resolved locally. Where local resolution is appropriate, it is in the best interests of the prisoner, who often needs issues to be resolved quickly. The Office will be reviewing and developing its informal resolution processes over the coming months to ensure that they are fit for purpose and that they are used appropriately.

Types of Complaints Recommendations

In 2008/2009, 70 recommendations were made by the Office covering a variety of issues.

Recommendations were made about...

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

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

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

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

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

... Rehabilitation:
- movement of prisoners to facilitate rehabilitation reassessment of risk
- development of appropriate reintegration action plans

... Disciplinary Issues:
- withdrawal of an adverse report
- quashing an adjudication
- provision of relevant material to prisoners going through the adjudication process.

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

... Review of Policies:

- adherence to policies
- risk assessments
- home leave
- adverse reports
- access to newspapers
- property that is allowed in prison
- smoking in prison
- health and safety when searching cells

Tracking of the Implementation of Recommendations

As reported earlier, new processes have been introduced this year to ensure that accepted recommendations are implemented. It is very much hoped this will help to build confidence in the complaints process as an effective method of resolving problems and concerns.

"If reoffending rates were cut by only 10 per cent that would release £1.2 billion which could be used to create new services for helping offenders including helping them beat their addictions."

Locked up Potential - Report by the Prison Reform Working Group, March 2009

DEATH IN CUSTODY INVESTIGATIONS

Overview

Since 1st September 2005, the Prisoner Ombudsman has been responsible for Death in Custody investigations and also has the discretion to investigate the deaths of former prisoners, where the circumstances may be relevant to the care received in prison.

This includes deaths from natural causes, accidental deaths, homicides, or where a prisoner has taken their own life.

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

Deaths in Custody Since 1st September 2005

Since September 2005, there have been 19 deaths in Northern Ireland Prisons. All of these prisoners were male. Eight were in custody in Magilligan prison and 11 in Maghaberry prison. The apparent causes of death were as follows:

Natural Causes/illness	8
Fresh water drowning	1
Drugs-Related	3
Suicide	4
Accidental *(as a result of a fall outside of prison)*	1
Head Injury *(as a result of an assault outside of prison)*	1
Legionella	1

Deaths in Custody During 2008/2009

Seven of the Deaths in Custody detailed above occurred in 2008/2009. Five of these deaths were in Maghaberry Prison and two were in Magilligan Prison. In two cases the prisoners took their own life, one was drugs related and four were due to illness/natural causes.

Three Death in Custody investigations were completed and reported in 2008/2009. Two of these related to Maghaberry and one to Magilligan. Recommendations arising from these reports covered the care of vulnerable prisoners, safer custody, de-briefing arrangements, care teams, use of mobile phones, Passive Drugs Dogs, drugs management, searching arrangements, communication between Health Care staff and discipline staff, and safety and unlocking procedures.

At the end of the year there were 11 investigations ongoing.

A decision was taken in September 2008 that all Death in Custody investigation reports completed after that date would be published on the Prisoner Ombudsman web site. One investigation, that into the death of Colin Bell in Maghaberry Prison, has been completed and published since that date.

Resourcing of Death in Custody Investigations

When the Office of the Prisoner Ombudsman was asked to assume responsibility for Death in Custody investigations in September 2005, no additional staff or resources were provided to support this additional and very important area of work. This has resulted in a backlog of cases and unacceptable delays in the time taken to complete what can be complex investigations. The impact these delays have on bereaved families, the Prison Service and the Coroner is a matter of considerable regret.

Building on existing work, the office has, since September, taken a number of steps to improve the efficiency and effectiveness of Death in Custody investigations. These are described in Section 3.

A Business Case for additional resources was submitted to the NIO in April 2009. At the time of going to press I have been informed that approval has been given for the appointment of one of the two additional investigator posts asked for and some additional non-recurring funding has been received.

Meanwhile, in support of a strategy to complete the investigation of the 11 outstanding cases, interviews were carried out in February 2009 to select an investigator from the Police Ombudsman's office from amongst applicants who had registered an interest in a development secondment. A second, specially selected, experienced external investigator has also been contracted to work with the team on a fixed-term arrangement.

It is hoped that the investigation of most of the current Death in Custody cases will be complete by December 2009.

The Colin Bell Death in Custody Investigation

The report into the death of Colin Bell in Maghaberry Prison was published in January 2009. The report contained 44 recommendations most of which related to the care of vulnerable prisoners and safer custody arrangements. The Minister for Criminal Justice said the death would be "a watershed" and put in place a Review Group and an Oversight Group, chaired by him, to take forward the recommendations and the wider safer custody agenda. The Criminal Justice Inspector will, during June and July, carry out an inspection of the care of vulnerable prisoners and will, as part of that exercise, review the implementation of the recommendations in the Colin Bell Death in Custody Report.

Implementation of Recommendations

The Colin Bell Report repeated a number of recommendations that had been made and accepted, but not implemented, as result of other investigations, inspections and reports. Concerns about the non-implementation of accepted recommendations have been raised a number of times. Agreement has been reached with the Prison Service that an action plan, with timescales, for all accepted recommendations will be produced immediately following consideration of a Death in Custody report. Contact will then be made with the Prison Service at appropriate intervals to seek confirmation of the implementation of recommendations, in line with the plan.

Death in Custody Investigations - Healthcare Issues

The delivery of Health Care services within prison transferred to the South Eastern Health and Social Services Trust in April 2008. Whilst responsibility for the investigation of prisoner complaints about Health Care has, therefore, also transferred from the Prisoner Ombudsman to the Northern Ireland Ombudsman, agreement was reached that the Prisoner Ombudsman, would continue to have overall responsibility for the investigation of Health Care aspects of Death in Custody investigations. The management of multi-disciplinary working, the different but complimentary roles of prison and Health Care staff, and the need for effective communication between them, are challenging areas that arise often in the context of investigations.

When carrying out a Death in Custody investigation the need to keep the Trust fully informed of progress and emerging issues in connection with the investigation is taken seriously. There is liaison with the Trust, as necessary, where an investigation has an external dimension. This can include, for example, issues in connection with the cancellation of hospital appointments, the transfer of information between hospital, or the community, and prison, and problems, sometimes raised by families, to do with the timeliness of diagnosis of serious conditions. The current arrangement is working well and avoids the difficulties and delays experienced by the Prisons and Probation Ombudsman in England and Wales, where arrangements for joint investigations exist.

Use of Expert Advisers

As part of Death in Custody investigations, independent, appropriately qualified experts, are engaged where necessary to carry out a full clinical review of the Health Care provided to a prisoner and to answer questions raised by the investigation and by the families. This year, steps have been taken to extend the list of experts from whom advice can be requested in order to ensure different specialisms are covered and to optimise the opportunity for varied inputs.

Foreign National Prisoners

In the last few years, the number of foreign national prisoners in Northern Ireland has risen sharply, from 181 committals in 2006/2007 to 291 in 2007/2008 to 547 in 2008/2009.

These prisoners have diverse religious and cultural needs, and in particular those for whom English is not their first language, have specific care needs. Prisoners lacking fluency in speaking and understanding English may feel lonely and isolated and struggle to make themselves and their needs understood. They may also experience great uncertainty and suffer from a lack of information about their future.

The Prison Service has made significant efforts to address some of the particular needs of foreign national prisoners, but many challenges remain.

Sadly, this year saw the first death of a foreign national prisoner when a prisoner in Maghaberry took his own life.[3]

Working with Bereaved Families

The death of a loved one in prison can be particularly difficult because of the limited information a family has about the last hours and days of the prisoner and the exact circumstances of the death. This year, family liaison arrangements have been developed and the office is committed to working closely with families in a way that is fully open and transparent but also sensitive to and respectful of their needs. Families are updated, at appropriate intervals, on emerging information and progress. The aim of our Family Liaison work is:

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

[3] The cause of death in this case has not yet been legally confirmed.

Research shows that providing prisoners with the skills they need to make a positive contribution to society on their release is good for the prisoner and good for communities.

Missing Personal Property

Peter complained that a number of personal items had gone missing from his cell following his transfer to the Special Supervision Unit (SSU). An Investigator met Peter to discuss his complaint in more detail. Peter explained that he had received grocery items just before going to the SSU, but when he was subsequently relocated to a residential house, these items were not among his possessions.

The Investigator traced several receipts for the items Peter stated he purchased.

Prison staff confirmed that when a prisoner is leaving the prison on release, or transferring to another prison, an inventory of all the prisoner's possessions is completed. This is signed by staff as confirmation that the items listed are correct and the list can be easily checked by the prisoner and staff to ensure all items are correct at the point of release. However, when a prisoner is moving within the prison, it is normally his own responsibility to pack up and take his belongings with him. In Peter's case the circumstances under which he was transferred meant he did not get the opportunity to pack his belongings and staff did this on his behalf. Staff working on Peter's landing around the time of his transfer said they could not recall packing his personal property.

The Ombudsman felt that as Peter had only recently bought many of the items that were missing, it was reasonable to consider that he would still have had them in his possession, in his cell, at the time of his transfer.

The Ombudsman therefore upheld part of Peter's complaint and made the following recommendations: The missing items that were verified as being recently purchased should be replaced, or their value placed into Peter's Personal Prisoners Cash (PPC) account. The Ombudsman also recommended that the Prison Service consider the use of an inventory form in circumstances where a prisoner does not have the opportunity to pack his own belongings during a move within the prison.

Temperatures at Night

Patrick complained that the heating in his block was not working and that at night he got particularly cold. An Investigator met Patrick to clarify the complaint in more detail. Patrick illustrated the problem by explaining conditions at night were such that when he dried tobacco behind his television, within a couple of hours it was wet again, due to the level of moisture in the air. As an asthma sufferer, the temperature was not good for his health.

Patrick said both staff and prisoners had previously complained about the temperature, and although it could be cold during the day, it was usually much colder at night. Patrick acknowledged that a survey had been carried out by the Trades Department in the past, but pointed out that the survey had only taken temperature readings during the day, not in the evening.

The Investigator spoke to staff who confirmed that the temperature within the block fluctuates and that on some occasions, the heating will not come on at all. Staff also confirmed that sometimes in the evenings they wear additional clothing because of the low temperature.

The Ombudsman confirmed that the survey carried out had not taken temperature readings in the evening, which would have given a fuller picture of the overall temperatures within the houses. As both staff and prisoners had complained about the temperature in the evenings a more comprehensive survey should take place to ascertain if there is a particular problem with the heating equipment.

In light of this information the Ombudsman upheld Patrick's complaint and recommended that the Prison Service carry out a further investigation of temperature levels and take appropriate action to rectify any heating problems.

Missing Mail

James complained to the Prison Service that mail posted to him approximately three weeks earlier had still not been received. After going through the Internal Complaints Process James was still not satisfied and contacted the Prisoner Ombudsman.

An Investigator visited James and discovered that initially James had been informed that no mail had been received. James was then told that this information was incorrect and that mail had been received but could not be traced. At this stage James was issued with an apology for any inconvenience caused.

Although he was grateful for the Prison Service admitting that mail had been received, and for issuing an apology, James was unhappy with the way in which his complaint was dealt with and wanted to know what had happened to his missing mail.

The Investigator contacted staff at the prison and examined the processes for dealing with incoming mail. Copies of all prison records relating to James' complaint were also obtained.

The Investigator also made enquires to establish if the missing mail had yet been found and what action, if any, had been taken to improve mail-handling procedures. The Prison Service explained that, regrettably, the mail had not been found.

The Investigator established there had been a change in procedures and that mail is now censored at the external gate search area, sealed in an envelope at the censor office, and taken to the residential house for distribution.

It was clear from the evidence gathered that the processes for dealing with incoming mail had not been effective in ensuring that mail was safely delivered, and in cases where mail was lost, in tracking the whereabouts of this mail.

The Ombudsman therefore upheld James's complaint and made the following recommendations: If not already in place, the new procedures should include some form of tracking system. This will help establish who last handled the mail if it goes missing in the future, and assist in obtaining an explanation for its whereabouts.

Drug Dog Indication

Michael complained that he had been given a closed visit with his parents because a drugs dog had indicated on his father. Following the visit, he asked prison staff what an indication entails and was informed that it was, 'when the dog sits down beside the person'. He said that this did not happen with his father.

Michael stated that his parents were now refusing to visit because of what he viewed as the 'harsh and victimising treatment' by the prison.

An Investigator met Michael to discuss the complaint in more detail; interviewed Michael's father and prison staff; viewed CCTV footage of two visits by Michael's parents to study the behaviour of the dog on both dates and visited the dog-training centre to gain a better understanding of how drugs dogs indicate.

Having examined the evidence, the Investigator stated that the CCTV footage generally supported Michael's father's account of what happened. The CCTV footage showed the dog sniffing at Michael's father's left foot. When the handler attempted to move the dog on, there was clear resistance from the dog and the dog was clearly excited and wagging its tail.

At the dog-training centre, the Passive Drugs Dog experts advised the Investigator that, although the dogs are trained to sit, this does not always happen and that, while the terminology "sit" or "sat" is used, an indication is considered to have taken place when the dog shows a marked change in behaviour. It was also pointed out that each dog indicates in a different way.

Having noted that there was a clear and marked change in the dog's behaviour when it approached Michael's father during his visit, the Ombudsman did not uphold the complaint, but did recommend that the Prison Service should review the terminology used when determining that a dog has indicated and discourage the generalised use of 'sit' or 'sat', which causes confusion. The Ombudsman also recommended that the recognised methods of indication for each dog should be recorded in the dog's individual record of service book.

Language Barrier

Mark sent a letter to the Ombudsman's Office expressing concerns over the difficulties he was experiencing because he cannot speak English.

The letter said he was unable to talk to staff and other prisoners, and was unable to read instructions or newspapers, or understand the television. He also said he was experiencing more serious personal difficulties, because he suffers from ill health and did not fully understand what was wrong with him or how he was being treated.

When he wished to raise an internal complaint about these matters, he said staff refused to accept it, as he had not written the complaint in English.

Although this complaint had not gone through the Internal Complaints Process, when this was brought to the attention of the Ombudsman, it was felt it was important to ensure facilities are in place to assist prisoners like Mark in making complaints.

As a result the Ombudsman recommended that the Prison Service provide Mark with newspapers and magazines in his language, suggested he attend English classes and be housed next to other prisoners who speak his language, allowing Mark to interact and converse with others, and to receive help when making a complaint.

Change in Length of Visiting Times

Enhanced Prisoners [prisoners who engage with both staff and other prisoners in a dignified manner and who also attend all classes and courses on a regular basis] in Ash House received four 1½-hour visits from family and friends per month, until the Governor changed the rules.

Under the new rules every Prisoner is now entitled to four 1-hour visits per month and enhanced visitors get one extra hour-long weekday visit. Susan complained that she now had 1 hour per month less visiting time and that trying to juggle work commitments with a weekday visit would cause problems for her family.

As the complaint was not resolved through the Internal Complaints Process, Susan complained to the Prisoner Ombudsman.

The Prisoner Ombudsman Investigator initially reviewed all the relevant prison rules and standards, establishing that all prisoners should receive a minimum of four 30-minute visits per month. The Investigator also confirmed the rules did not stipulate that Enhanced Prisoners should receive additional visits.

The Governor explained to the Investigator that he was trying to make visiting fairer for everyone in prison as, before the rule change, some prisoners had only the minimum of 2 hours of visits per month, which was 4 hours less than the visiting time Susan was receiving.

The Ombudsman recognised the importance of all families having the opportunity to maintain as much contact as possible with their family member in prison. Whilst understanding that Susan was unhappy because she was receiving 1 hour less per month than previously, the Ombudsman decided that the new rules provided improved visiting arrangements for a greater number of prisoners and their families and the complaint could not be upheld. The Prisoner Ombudsman Investigator discussed with Susan options for providing assistance to her family with travel arrangements for visits.

Attending Sunday Service

John had been transferred to the Special Supervision Unit (SSU) as the result of an adjudication arising from disobeying an order. Whilst in the SSU he made a request on Wednesday to attend a Sunday Service the following Sunday. This request was refused and John complained, because he said both prison rules and his rights were being breached.

As the complaint was not settled through the Internal Complaints Process, John complained to the Prisoner Ombudsman.

An Investigator began the investigation by reviewing the current prison rules and relevant legislation. The Investigator found that standing orders permitted a prisoner undergoing punishment to attend Sunday Services, with the permission of the Governor.

However, through interviews with Prison Staff and the Governor the Investigator established this discretion was not being exercised and that no one in the SSU was being allowed to attend Sunday Service.

When a request to attend Sunday Service was made, the practice in the SSU was that the relevant Chaplain would be informed and would endeavour to visit the prisoner in his cell. However, in John's case it was established that the Chaplain had not been informed John had made a request to attend Sunday Service.

The Prisoner Ombudsman determined that the complaint should be upheld. It was recommended that all prisoners in the SSU are made aware of their right to practice their religion and are informed as to how to make a request to do so. The Ombudsman also recommended that requests should not be automatically refused but should, in line with Prison Service policy, be subject to individual risk assessment. When a prisoner is not permitted to attend church services, an explanation should be given and a visit from the Chaplain offered.

Reduction in Gym Allocation

Tom, who was an enhanced prisoner on the Progressive Regimes and Earned Privileges Scheme (PREPS), had his gym allocation cut from five sessions per week to three. Tom felt that he was being discriminated against, as Enhanced prisoners in other prisons were still attending five sessions of gym each week. He complained, using the Internal Complaints Process, and was told that the reduction in sessions was because there was only one gym for over 450 prisoners and there were exercise facilities available in the residential area that could be used in addition to the gym.

The Prisoner Ombudsman Investigator interviewed Tom to clarify his complaint, interviewed staff and examined gym attendance records. The Investigator noted that Prison Rules provided limited guidance on this subject stating only that every prisoner shall be given exercise in the open air, weather permitting, for one hour per day.

It was clear from the evidence that gym sessions were being allocated to meet the needs of an increasing prison population and that this was the reason for the reduction in Tom's sessions. It was also clear that while use of the gym was highly desirable, some prisoners do not turn up for gym sessions. This meant that at times there might be as few as 10 people in the gym.

The Prisoner Ombudsman, therefore, upheld the complaint and recommended that there should be a review of the current timetable with a view to improving the allocation of gym time for prisoners who are keen to exercise.

Payments Relating to Working out Scheme

The Working-out Scheme is a programme available to prisoners nearing the end of their sentences to help them start to earn money and to reintegrate back into society. Kelly complained to the Prisoner Ombudsman that she had not received all the payments due to her from the Working-out Scheme.

In her letter to the Prisoner Ombudsman, Kelly highlighted that one benefit of the working-out scheme was statutory entitlement to a single person's benefit of £60.50 per week. Kelly said she had not been paid for two weeks on the scheme, and was owed £121.

Kelly explained she could not raise the matter as an Internal Complaint as the amounts payable were only available after her release from prison.

An Investigator discussed Kelly's complaint with the Governor, who apologised there had been no response to a query from Kelly after her release. The Governor agreed to check if Kelly was owed money and to provide the Investigator with a detailed record of the amounts due, paid and outstanding.

The detailed records showed Kelly's entitlement came to a total of £914.43 and she had been paid £849.90, leaving a balance of £64.53. The Investigator let Kelly examine the records, which she agreed were correct and signed an agreement stating that the outstanding balance of £64.53 was correct. She said once the payment was received she would consider the complaint resolved.

The Prisoner Ombudsman upheld Kelly's complaint and recommended that the Prison Service arrange to have the outstanding balance of £64.53 paid immediately.

Removal of Guitar Strings

A visitor left Kevin a guitar in at reception. When he went to collect the instrument, Kevin was told that he had to remove the strings, as security had deemed them a risk, and he should buy new ones from the tuck shop. There was also a stud missing from the bottom of the guitar.

Three months later Kevin claimed to have found a crack in the guitar. He initiated the Internal Complaints Process claiming that he was not worried about the missing stud but that he was very concerned about the crack. At this time he also said he felt it was unfair he had to meet the cost of buying new guitar strings because he had been asked by the Prison Service to remove the existing ones.

During the Internal Complaints Process, the Prison Service apologised that Kevin had been misinformed when he was told the guitar strings must be removed and this was not in fact necessary. The Prison Service also said that since Kevin had been in possession of the guitar for three months, it was impossible to say how the crack in the guitar had come about.

As Kevin had exhausted the Internal Complaints Process the Prisoner Ombudsman accepted his request to investigate.

The Prisoner Ombudsman reviewed the relevant records and acknowledged the three-month time difference between Kevin collecting the guitar and reporting the crack in the instrument. It was also noted that the instruction that Kevin remove his guitar strings had been an error.

The Prisoner Ombudsman concluded that it would be impossible to be certain when the damage had occurred. However, the aspect of the complaint relating to the removal of the strings was upheld. As Kevin had been misinformed about the supposed security need to remove his guitar strings, and had to buy replacement strings, the prison should reimburse the cost of the strings.

APPENDICES

Appendix 1

Terms of Reference for Investigation of Complaints

1. The Prisoner Ombudsman, who is appointed by the Secretary of State for Northern Ireland, is independent of the Northern Ireland Prison Service and reports to the Secretary of State.
2. The Ombudsman will investigate complaints submitted by individual prisoners and ex-prisoners who have failed to obtain satisfaction from the NIPS complaints system and who are eligible in other respects.
3. The Ombudsman will normally act on the basis only of eligible complaints from those individuals described in paragraph 2 (above) and not on those from other individuals or organisations.
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:
   - policy decisions taken by a Minister and the official advice to Ministers upon which such decisions are based:
   - the merits of decisions taken by Ministers, except in cases which have been approved by Ministers for consideration by the Prisoner Ombudsman;
   - the personal exercise by Ministers of their function in the certification of tariff and the release of mandatory life sentenced prisoners;
   - actions and decisions outside the responsibility of the NIPS such as issues about conviction and sentence; cases currently the subject of civil litigation or criminal proceedings, and the decisions and recommendations of outside bodies such as the judiciary, the police, the Director of Public Prosecutions, the Immigration Service, the Probation Service, the Sentence Review Commissioners, Life Sentence Review Commissioners, Remission of Sentences Commissioners, Loss of Remission Commissioners and their secretariat;
   - actions and decisions taken by contracted-out service providers; and
   - the actions and decisions of people working in prisons but not employed in NIPS.

Submitting Complaints and the Limits

7. Before putting a grievance to the Ombudsman, a complainant must first seek redress through appropriate use of the NIPS complaints procedures. Complainants will have confidential access to the Ombudsman and no attempt should be made to prevent a complainant from referring a complaint to the Ombudsman.
8. The Ombudsman will consider complaints for possible investigation if the complainant is dissatisfied with the reply from the NIPS or receives no final reply within six weeks.
9. Complainants submitting their case to the Ombudsman must do so within 30 days of receiving a substantive reply from NIPS. However, the Ombudsman will not normally accept complaints where there has been a delay of more than 12 months between the complainant becoming aware of the relevant facts and submitting their case to the Ombudsman, unless the delay has been the fault of NIPS.
10. Complaints submitted after these deadlines will not normally be eligible. However, the Ombudsman has discretion to consider those where there is good reason for the delay, or where the issues raised are so serious as to override the time factor.

Determining Eligibility of a Complaint

11. The Ombudsman will examine complaints to consider whether they are eligible. To assist in this process, where there is some doubt or dispute as to the eligibility of a complaint, the Ombudsman will inform NIPS of the nature of the complaint and, where necessary, NIPS will then provide the Ombudsman with such documents or other information as the Ombudsman considers relevant to considering eligibility.
12. The Ombudsman may decide not to accept a complaint or to continue any investigation where it is considered that, the complaint is vexatious or repetitious or frivolous or no worthwhile outcome can be achieved or the complaint raises no substantial issue. The Ombudsman is also free not to accept for investigation more than one complaint from a complainant at any one time unless the matters raised are serious or urgent.

Access to Documents for the Investigation

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

Local Settlement

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

Visits and Interviews

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

Disclosure of Sensitive Information

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

Draft Investigation Reports

18. Before issuing a final report on an investigation, the Ombudsman will send a draft to the Director General of NIPS, to allow the Prison Service to draw attention to points of factual inaccuracy, to confidential or sensitive material which it considers ought not to be disclosed, and to allow any identifiable persons subject to criticism an opportunity to make representations.

Recommendations by the Ombudsman

19. Following an investigation all recommendations will be made either to the Secretary of State or the Director

General of NIPS, as appropriate, to their roles, duties and powers.

Final Reports Responses to Complaints

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

21. The Ombudsman has a target date to give a substantive reply to the complainant within 12 weeks from accepting the complaint as eligible. Progress reports will be given if this is not possible.

NIPS Responses to Recommendations

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

Annual Report

23. The Ombudsman will submit an annual report to the Secretary of State, following the end of the financial year. The report will include:

- a summary of the number of complaints received and answered, the principal subjects and the office's success in meeting time targets;
- examples of replies given in anonymous form and examples of recommendations made and of responses;
- any issues of more general significance arising from individual complaints on which the Ombudsman has approached the NIPS; and
- a summary of the costs of the office.

Appendix 2

Terms of Reference for Investigation of Deaths in Prison Custody

1. The Prisoner Ombudsman will investigate the circumstances of the deaths of the following categories of person:

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

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

3. The aims of the Ombudsman's investigation will be to:

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

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

Clinical Issues

5. The Ombudsman will be responsible for investigating clinical issues relevant to the death where the 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,

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.

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

The number of foreign national prisoners in the Northern Ireland prison system has doubled in recent years. This presents new challenges.

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