



The  
**Prisoner  
Ombudsman**  
for Northern Ireland

## PRISONER OMBUDSMAN FOR NORTHERN IRELAND

# ANNUAL REPORT 2015-16



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**I am pleased to present my Annual Report for the period April 2015-March 2016.**

The role of the Prisoner Ombudsman is to investigate and report on deaths in custody and complaints from prisoners.

Our work is entirely demand-led, which means volumes are unpredictable. During 2015-16 we commenced investigations into two deaths in custody, one less than last year. Both involved Maghaberry prisoners: one appeared to be self-inflicted and the other due to natural causes. There were no deaths in Magilligan, Hydebank Wood or Ash House during the year.

We received 1,593 complaints, an 11% increase on last year. While complaint rates from Magilligan prison, Ash House and Hydebank Wood remained very low, it is significant that there was a 25% increase in complaints from integrated prisoners at Maghaberry Prison. Around three quarters of all complaints came from separated Republican prisoners held on Maghaberry's Roe 4 landing.

Concerns that I expressed about Maghaberry in last year's annual report were highlighted in a report which was published by the Criminal Justice Inspectorate in November 2015. Amid a range of criticisms it found Maghaberry's Internal Complaint Process was "*in disarray*."

The Northern Ireland Prison Service (NIPS) subsequently deployed additional staff to Maghaberry and changed the management team. These measures - along with a significant reduction in the prison population - helped stabilise the prison, and a follow-up inspection reported improvements in the Internal Complaints Process by January 2016.

We upheld 41% of prisoners' complaints, 3% less than last year. While the majority related to procedural failings, their significance for complainants, and for stability of the prisons, should not be underestimated: matters such as lengthy lockups, delayed mail and loss of privileges can seriously unsettle prisoners who have limited opportunities for contact with their families and few personal possessions.

My office experienced inordinate delays in obtaining material for complaint and death in custody investigations from the NIPS and the South Eastern Health & Social Care Trust (SEHSCT), and in receiving factual accuracy responses to draft reports. While I recognise the Prison Service's and Trust's operational priorities, it is important that this situation improve if the benefits of publicly-funded prison oversight are to be fully delivered.

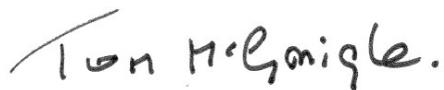
There were some positive developments during 2015-16:

- Legislation was passed by the Northern Ireland Assembly in March 2016 to place my office on a statutory footing. It is hoped the supporting Regulations can be drafted in time for the legislation to commence in early 2017;

- An independent review of our complaints-handling practice was commissioned by the Department of Justice (DoJ). The review findings were very positive and it was published in November 2015;
- Our 2015-16 internal audit gave a “*Substantial Assurance*” rating and made no recommendations for improvement.

Five staff - almost half our total complement - moved on from the office during 2015-16. While it is helpful that the Department of Justice maintained the overall headcount, their departure represented a significant loss of familiarity with prison culture, personnel and processes. A key task for the incoming year is therefore to begin rebuilding this important knowledge base.

I am grateful to all who supported our work, especially everyone in my office for their contributions to an important public service during 2015-16.



**Tom McGonigle**  
**Prisoner Ombudsman for Northern Ireland**

**June 2016**

## Background

The Prisoner Ombudsman's Office was set up in 2005 following the Steele review into separated conditions, which suggested that 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 (DiC).

The Prisoner Ombudsman's powers regarding investigation of complaints by prisoners or visitors to prison establishments are currently set out in Rule 79 of the Prison & Young Offender Centre (NI) Rules 2009.

The Prisoner Ombudsman has a standing commission from the Director General of the NIPS to investigate deaths in prison. He does not have any statutory powers in this matter.

All our investigations are guided by *“The Principles of Good Complaints Handling”* which are Clarity of Purpose, Accessibility, Flexibility, Openness and Transparency, Proportionality, Efficiency, and Quality Outcomes. Terms of Reference govern the investigations. They can be found on the website [www.niprisonerombudsman.gov.uk](http://www.niprisonerombudsman.gov.uk). Detailed manuals have been developed to guide staff in their investigations and these are regularly updated.

We believe 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 Death in Custody 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 Coroner's Office, so that the facts plus our analysis and recommendations are shared with those who are directly affected. Our preference is to publish Death in Custody reports in full in order to serve the public interest. However we must balance publication 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 when 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 identifiable staff who are subject to criticism. 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 bi-annual 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*

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#### Principle 1 - INDEPENDENCE

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

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#### 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.

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#### 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 and healthy regime.

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#### 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.

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#### Principle 5 - EFFICIENCY

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

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#### Principle 6 - FORWARD LOOKING

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

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## Organisational Structure and Responsibilities

The first Prisoner Ombudsman for Northern Ireland was appointed in 2005. The current (third) Prisoner Ombudsman - Tom McGonigle - was appointed by the Minister of Justice on 1<sup>st</sup> 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; and he meets regularly with and the South Eastern Health and Social Care Trust in respect of death in custody investigations. For corporate governance purposes the Prisoner Ombudsman’s Office is treated as an Advisory Non-Departmental Public Body.

Corporate governance is delivered through biannual formal meetings with the sponsoring Division of the DOJ (Policing Policy & Strategy Division/Probation and Prisoner Ombudsman Branch), at which key corporate documents and processes are reviewed. Financial probity is overseen by the DOJ Internal Audit Unit. An Annual Report is prepared after the end of each financial year and published on the 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

On 31<sup>st</sup> March 2016 the staff complement comprised 10.62 posts/11 people:

Prisoner Ombudsman (4 days per week)  
Director of Operations  
2 x Senior Investigators (1 @ 30 hrs per week)  
5 x Investigators; and  
2 x Administrative Support staff.

There were significant staff changes during the year: the Senior Complaints Investigator and an Investigator left under the NICS Voluntary Exit Scheme; another Investigator resigned to develop her career; and two Administrative Support staff transferred within the NICS. This

meant that almost half our total staff complement moved on. It helped that the DoJ agreed to maintain the office's core complement of Investigators and as a result there was no loss to the overall headcount. However their departure represented a significant loss of familiarity with prison culture, personnel and processes. A key task for the incoming year is therefore to begin rebuilding this important knowledge base.

The Prisoner Ombudsman is a public appointee and all other staff are established civil servants, apart from one Investigator who is seconded via the Interchange programme.

Staff undertook the full range of NICS-required training during 2015-16. This was delivered online and included Health & Safety Awareness, Performance Management and Display Screen Equipment.

New Investigators spent time with the NIPS as part of their induction. This has proven to be a useful practice, with the emphasis on learning about Prison Service processes such as adjudications, home leave decisions and prisoner safety meetings.

The Prisoner Ombudsman's office aims to conduct itself according to the best current principles, and to serve as an example of good management practice. The terms and conditions of staff members are those of the 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 are also expected to comply with the standards and principles laid down in the Civil Service Management Code, the NICS Standards and Conduct guidance and the NICS Code of Ethics. These set out in detail the rules governing confidentiality, data protection, acceptance of outside appointments and involvement in political activities.

## **Finance**

The 2015-16 operating budget was £579,000, of which 90% 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.

Budgetary savings were achieved by not replacing a part-time Personal Assistant who transferred, and by delays in replacing other staff who moved on.

## **Corporate and Business Planning**

We continued to work to the Corporate Plan for 2014-17 which was published in March 2014. It provides the organisation's strategic and operational framework. A Business Plan for 2015-16 was published in March 2015, setting out more precisely the annual objectives and resources employed to achieve them.





**George Richardson, Director of Operations**

### Statistical Headlines for 2015-16

- Investigations initiated into the deaths of two prisoners and four ex-prisoners
- Ten draft investigations completed – one death in custody, two serious self-harm incidents and seven post-release deaths
- 1,593 complaints received, an increase of 11% from 2014-15
- 98% of all complaints came from Maghaberry
- 128 recommendations for improvement made in complaint reports: 41% accepted / 49% overdue for response at time of writing
- 42 recommendations for improvement in Death in Custody reports, all of which were accepted.

### Performance against targets

#### 1. Statutory Footing

1. Identify issues to be included in the legislation and supporting regulations.  
*Achieved via regular engagement with DoJ officials and members of the Justice Committee of the Northern Ireland Assembly. The Justice Committee passed the Justice [No2] Bill in September 2015; and the full Assembly passed the Bill on 14<sup>th</sup> March 2016. It is hoped the supporting Regulations can be drafted in time for the legislation to commence in early 2017.*
2. Contribute to the DoJ Statutory Footing Project Board.  
*Not applicable as the Project Board - whose role is to develop the detailed Regulations that will support the legislation - could not be established until the Bill had passed into legislation.*
3. Scope and address the implications for current PO staff, particularly in light of the Voluntary Exit Scheme.  
*Achieved. While it was helpful that the Department of Justice replaced staff who left, there has been a significant loss of corporate memory and familiarity with prison life, personnel and processes. Rebuilding this will therefore be a key task for the incoming year.*

4. Prepare for an extension to our remit to include contribution to investigations at the Juvenile Justice Centre for Northern Ireland, if this proposal is approved by the NI Assembly as part of the statutory footing process.  
*This has been provided for in the Justice (No2) Bill.*

## 2. Complaints and DiC Investigations

1. Produce investigation reports which are evidence-based and impartial.  
*The factual accuracy process is effective in achieving this objective and no complaints were lodged about the quality of our investigations or reports. Opinions about report quality are often subjective, especially if the evidence is inconclusive. When informal challenges were mounted we reviewed the evidence to ensure adherence to the Rules and Terms of Reference.*  
  
*Acceptance of all DiC recommendations and most complaint recommendations also indicates achievement of this objective.*  
  
*The independent "Review of Complaints-Handling in the Office of the Prisoner Ombudsman" which was published in November 2015, confirmed the investigations and reports examined were evidence-based and impartial.*
2. Ensure full compliance with Complaints and Death in Custody Terms of Reference by Investigators.  
*Internal review of all DiC reports and dip samples of complaint reports continued to provide useful quality control mechanisms. They indicated compliance with the Terms of Reference, especially the important principles of evidence-based and impartial practice. Feedback was provided to Investigators individually and collectively in order to support their professional development.*
3. Adhere to timescales (nine months for draft DiC reports and 18 weeks for final Complaints reports) in all investigations.  
*Partially achieved: our routine operation was consistently frustrated by inordinate delays in receiving material from the SEHSCT and the NIPS for investigations, and in receiving factual accuracy responses to draft reports. While I recognise the Prison Service's and the Trust's operational priorities, it is important that this situation improve if the benefits of publicly-funded prison oversight are to be fully delivered.*
4. Commission an independent review of our professional practice in investigating and reporting on Complaints.  
*The independent "Review of Complaints-Handling in the Office of the Prisoner Ombudsman" was commissioned and funded by the DoJ, and delivered in November 2015.*
5. Ensure an Investigator is on site within four hours of being notified about a death in custody.  
*Achieved*
6. Update Complaints and DiC Terms of Reference once the position is clear in respect of statutory footing.  
*Still pending as the position in respect of statutory footing only became clear in March 2016. This objective will be carried over to 2016-17 as it can only be undertaken in conjunction with development of Regulations.*

7. Review and update Complaints administration processes and the Complaints Database.  
*Administration processes, including the complaints database have had to be continuously adapted due to the volume of complaints received.*
8. Apply mechanism agreed with the NIPS for monitoring implementation of accepted recommendations via a dip sample.  
*Partially achieved: monitoring of recommendations has been manageable at Hydebank Wood and Magilligan, but problematic at Maghaberry where the volumes involved were considerable.*
9. Identify ways to assess implementation of recommendations in conjunction with other oversight bodies e.g. Independent Monitoring Boards, Criminal Justice Inspectorate, Regulation & Quality Improvement Authority and the International Committee of the Red Cross.  
*Partially Achieved – CJINI provided feedback in relation to DiC recommendations in the January 2016 inspection of Maghaberry Prison.*
10. Maximise accessibility for everyone who has contact with our services. Ensure low user groups – such as foreign national prisoners, young offenders and visitors - have opportunities to understand the role of the Prisoner Ombudsman.  
*We continued to address underuse of our service by certain groups. Efforts this year included maintaining the bi-monthly “clinic” at Hydebank Wood for young male prisoners; and contributing to foreign national prisoners fora at Maghaberry. While the numbers of formal complaints from low user groups has not increased, we identified several local concerns and achieved prompt responses after raising them with prison managers.*  
  
*We also regularly visited Ash House Women’s prison and raised issues with governors that prisoners there reported to us informally.*  
  
*We held a clinic at Maghaberry Visitors Centre in March 2016 and agreed with the manager to develop this into a regular event in 2016-17.*  
  
*“Inside Issues” was prepared and circulated to every prisoner in July 2015 and January 2016.*

### 3. Support for NIPS Complaints Handling

1. Assist the NIPS to improve local resolution of complaints. In 2015-16 this will include comparison against the baseline established during 2014-15.  
*Not achieved, mainly because this was a low priority for the NIPS due to volume of complaints in Maghaberry Prison.*
2. Contribute to relevant consultation exercises, conferences and other events to share the findings of Complaint and DiC investigations.  
*The Prisoner Ombudsman gave interviews to local broadcast and print media about topics that included Death in Custody publications, the 2014-15 annual report and the inspection of Maghaberry Prison that was published in November 2015.*  
  
*The Ombudsman contributed to the Ministerial Forum on Safer Custody and was closely involved in developing the statutory footing legislation.*

#### 4. Support for NIPS Reform

1. Meet monthly with the NIPS Director General, and quarterly with prison governors to share feedback from investigations and other matters of mutual interest.  
*Formal meetings with the NIPS Director General and prison governors continued throughout the year to discuss DiC and Complaint findings, address areas of concern and recognise progress.*
2. Meet regularly with other stakeholders including the SEHSCT, CJI, Independent Monitoring Boards, the Coroner, RQIA, ICRC and the Northern Ireland Ombudsman to share feedback from investigations and other matters of mutual interest.  
*The Prisoner Ombudsman and Director of Operations met with these stakeholders throughout the year, and also with others such as the International Committee of the Red Cross.*
3. Contribute to the training of NIPS staff if requested.  
*The Ombudsman and Director of Operations contributed to several training events for NIPS Senior Officers and new recruits.*
4. Engage with other government departments to support policy-making that assists prison reform.  
*Not achieved - we had limited engagement with other government departments as prisons were considered to be a specific Justice area of responsibility.*

#### 5. Corporate Affairs

1. Adapt to budgetary reductions (5% reduction scheduled for 2015-16) and associated changes;  
*Achieved - we remained within budget during 2015-16.*
2. Prioritise investigative capacity in event of further staff reductions;  
*Achieved. The DoJ agreed that we should retain our investigative capacity at a time when other NICS departments lost staff on the VE Scheme. We forfeited 0.5 administrative post, and a Senior Investigator, two Investigators and an administrator moved on, which caused considerable disruption. However the Investigator headcount remained intact.*
3. Communicate implications of staff changes clearly to all stakeholders  
*Achieved, primarily via the Annual Report and "Inside Issues" biannual newsletter for prisoners.*
4. Publish annual report by September 2016.  
*Achieved*

## Complaints

*We received 1,593 eligible complaints, 11% more than last year.*

### Context

Independent investigation of complaints can help instil in prisoners greater confidence that their welfare is treated seriously. It can also help reduce tension and promote better relations. The NIPS Internal Complaints Process (ICP) is underpinned by the principle that prisoners have a 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 April 2015 – March 2016 shows:

11,174 (9,456 last year) complaints were made, of which:

- 5,117 (46%) were closed at Stage 1
- 3,983 (36%) were closed at Stage 2
- 641 (6%) were closed upon the prisoner's release
- 1,432 (12%) were still open at the end of the year

When complaints from separated Republican prisoners on Maghaberry's Roe 4 landing (4,578) are removed from the equation, the number of complaints made by other prisoners (6,596) was close to the previous year (6,431).

There are various reasons for complaints being closed. These range from prisoners receiving a reasonable answer, through to being discharged from custody or abandoning their complaint. Part of the explanation is however a failure to effectively deal with complaints at the first or second stages. This creates drivers for additional complaints, resulting in a real cost to overall NIPS business.

During the year we found many Maghaberry complaints where the NIPS did not address the issue that was raised, did not answer at Stage 2 at all, or the Stage 2 response simply reiterated the response given at Stage 1. None of these approaches instils confidence in prisoners that they are being treated seriously.

Complaints only become eligible for investigation by our office after NIPS ICP Stages 1 and 2 have been exhausted. Prisoners also have other means of seeking redress for their grievances: Independent Monitoring Board volunteers visit the prisons regularly and perform a valuable advocacy role which prevents several issues from turning into complaints; and many prisoners raise their concerns via the Judicial Review process.

Table 1 illustrates that 98% of complaints to our office came from Maghaberry Prison, a rate similar to last year. Like young men in custody elsewhere, those in Hydebank Wood made little use of the official complaints system; and complaints from the women prisoners in Ash House were roughly proportionate to their numbers. Magilligan's complaint numbers also remained low, and less than last year, reflecting the more stable population held in that prison and an emphasis on local resolution before complaints were escalated.

**Table 1 – Eligible complaints received April 2015 – March 2016**

Location	Total	Percentage of all complaints	Percentage of complaints excluding Roe 4	Percentage of overall prison population on 31 March 2016
Roe 4	1,248 <sup>1</sup>	78%	-	2%
Maghaberry Others	314	20%	90%	57%
Magilligan	28	2%	9%	31%
Hydebank Wood	0	-	-	7%
Ash House	3	-	1%	3%
<b>Overall Total</b>	<b>1,593</b>			

## **Roe 4**

Separated Republican prisoners held on Roe 4 landing at Maghaberry Prison continued to lodge large volumes of identical complaints, and routinely refused to accept responses at Stages 1 and 2 of the NIPS Internal Complaints Process. During 2015-16 they comprised 2% of the total prison population, but made 78% of the complaints that were received by our office. The prisoners' main concerns involved controlled movement, full body searching and refusal of permission for a small number of other prisoners to join them on Roe 4.

As was agreed with the prisoners and with the NIPS last year, we continued to group these complaints in order to reduce investigative and administrative pressures.

We investigated and reported on Roe 4 prisoners' complaints in line with the Rules and Terms of Reference, in the same way as all other complaints and in line with our duty of impartiality and independence. However the tensions continued: an intervention by the International Committee of the Red Cross during 2015 was unable to reach a resolution; and the murder of an off-duty prison officer in March 2016 was linked to the Roe 4 situation. It therefore remained difficult for our office to offer creative solutions to the situation that prevailed there.

## **Integrated Prisoners**

345 complaints from integrated prisoners in NIPS custody were escalated to our office, a 25% increase on 2014-15. This figure is all the more significant as there was a substantial drop in the prison population: it was 257 lower on 1<sup>st</sup> April 2016 than on 1<sup>st</sup> April 2015, mainly due to a prolonged legal aid dispute.

An inspection in May 2015<sup>2</sup> found that Maghaberry's Internal Complaints Process was "in disarray." A follow-up inspection in January 2016<sup>3</sup> found the ICP was better organised, and

<sup>1</sup> An additional 1,836 complaints from Roe 4 prisoners were received, but had not yet been registered at year end.

<sup>2</sup> <http://www.cjini.org/CJINI/files/a9/a98fca95-ae81-4443-88cc-1870be44250f.pdf>;

<sup>3</sup> <http://www.cjini.org/CJINI/files/4a/4a4b596d-24bb-418f-a50c-9da353df0d88.pdf>

80% of outstanding complaints had been addressed. However with 1,432 complaints still open at the end of March 2016, there is still a way to go to fully redress this situation.

88% of the complaints that we received were made by sentenced prisoners, and only 12% came from remand prisoners.

**Table 2 – Maghaberry complaints received by location April 2015 - March 2016**

Location	Number of Complaints
Bann	17
Braid	38
Bush	12
CSU	51
Erne	63
Foyle	67
Lagan	20
Moyola	0
Quoile	22
Released	0
Roe 1,2 & 3	5
Roe 4	1,248
Shimna	13
Visitor	0
Wilson	6

We cleared a total of 1,515 complaints during 2015-16: 266 from integrated prisoners, and 1,249 from prisoners on Roe 4 at Maghaberry.

**Table 3 – All complaint outcomes April 2013 – March 2016**

	Upheld	Not Upheld	Partially Upheld	Local Resolution	Withdrawn/ Released	Total
2015-16	616 (41%)	657 (43%)	146 (10%)	31 (2%)	65 (4%)	1,515
2014-15	473 (44%)	227 (21%)	173 (16%)	143 (14%)	52 (5%)	1,066
2013-14	216 (46%)	136 (29%)	26 (6%)	58 (12%)	32 (7%)	468

While the majority of upheld complaints related to procedural failings, their significance for complainants should not be underestimated: matters such as lengthy lockups, delayed mail and loss of privileges can seriously destabilise prisoners who have limited opportunities for contact with their families and few personal possessions.

We made a total of 128 recommendations for improvement in response to prisoners' complaints during 2015-16. At the time of writing 52 of these had been accepted and 17 were not accepted. Fifty-nine were still awaiting a response, of which 49 were overdue by up to a year.

The delays in obtaining material from the NIPS and in receiving factual accuracy responses to draft reports were inordinate and longer than last year. The NIPS explained they were due to the large volume of complaints, combined with significant levels of staff changes and personnel shortages. While I recognise the Prison Service's operational priorities, it is important that this situation improve if the benefits of publicly-funded prison oversight are to be fully delivered.

**Table 4 – Maghaberry Integrated Prisoners Main Complaint Topics 2015-16**

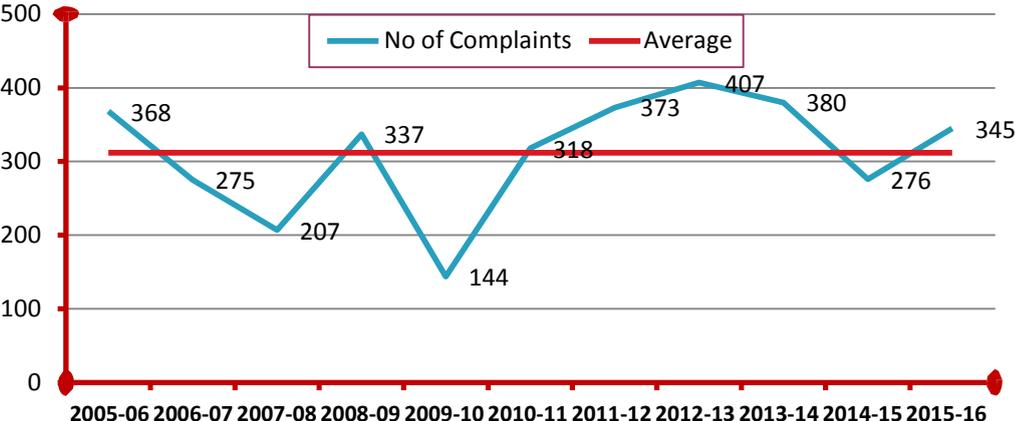
Topic	2015-16	2014-15	2013-14	2012-13
Property and Cash	32	35	48	43
Visits	15	10	46	24
Staff	61	35	46	36
Accommodation	51	43	41	7
Adjudications	6	6	15	4
Mail	9	3	21	7
Searching	6	13	21	9
Transfers	9	12	19	17
Health & Safety	12	0	18	6
Regime level	7	4	15	19
Home leave	-	7	15	15
Lock down	13	12	14	22
Discrimination	7	3	13	16
Education	31	9	12	5
Adverse reports	3	5	10	4
Miscellaneous	152	79	96	163
<b>TOTAL</b>	<b>314</b>	<b>276</b>	<b>450</b>	<b>407</b>

### Comparisons

Figure 1 below indicates that complaint trends have been erratic over the years. This data needs to be treated with caution as recording methods have changed: earlier figures may include complaints that were counted twice by being received in one year and concluded in the following year; the distinction between “Eligible” and “Ineligible” complaints was not always clear; and Healthcare complaints were removed from the Prisoner Ombudsman’s remit in 2008.<sup>4</sup>

<sup>4</sup> The Prisoner Ombudsman however still investigates the Healthcare dimension of Deaths in Custody.

**Figure 1 - Eligible Complaints Received 2005-2016 (excluding separated Republican prisoners' complaints)**



Complaints to the Prisons & Probation Ombudsman for England & Wales increased by 13% in 2014-15 from the previous year; and he upheld 39%, an increase of 5% from the previous year.

## Complaint Case Studies

### Confidential Telephone List

Mr A complained about the NIPS refusal to add his solicitor's mobile number to his confidential telephone list.

The NIPS stated that *“Any legal telephone number submitted by a prisoner must be verified by prison staff and this is not possible with mobile numbers. This is to prevent prisoners from being able to use the guise of legal confidentiality to make unmonitored calls that do not merit confidentiality.”* We argued that it would be possible to verify that a mobile phone number belonged to a particular legal representative, but the NIPS further responded by saying *“There is a higher risk, given the transient nature of mobiles, that a number or phone verified at a point in time for this purpose could be used for another reason. With a landline to a verified office address this risk is significantly lower.”*

We established that there has not been a prohibition on prisoners in England phoning their solicitors' mobile telephones since 2001. A number of safeguards, including checks with the Law Society and Bar Council, are in place to verify that the mobile phone does in fact belong to the prisoner's solicitor.

On that basis we upheld the complaint and recommended that that NIPS adopt the approach operated by the NOMS. The NIPS was unwilling to accept this recommendation, largely for the reasons outlined to our investigation.

### Regime progression

Mr B complained about not being allowed to progress beyond Standard Regime level. The NIPS had advised him this was because he was not fully engaging with his sentence plan, which is required for promotion to Enhanced Regime. The sentence plan required him to undertake the Sex Offender Treatment Programme, but he was deemed unsuitable for it because he continued to deny the charges for which he had been convicted.

The complainant countered that he was appealing his conviction and would continue to deny the offences. However while he had asked the Criminal Cases Review Commission to review his case, it is not a formal appeal mechanism, and he had not lodged any appeal with the courts in Northern Ireland.

There is no alternative to the SOTP for convicted sex offenders in Northern Ireland; and as the NIPS was operating the SOTP in line with official guidance, we did not uphold the complaint.

### Security Category Review

Mr C complained that his Security Category Review was overdue and this was impacting on his pre-release progression. The NIPS accepted his complaint and he had been assured it would be scheduled *“in the very near future.”* However by the time he escalated it to us the review was thirteen months overdue.

The NIPS Security Manual states that *“All Category B/C, medium and high supervision prisoners must be reviewed annually.”* On that basis we upheld Mr C's complaint, recommended the review should be carried out without delay, and that all Security Reviews should be

conducted in line with the NIPS Security Manual. The NIPS accepted the recommendations and subsequently confirmed that the complainant had been reclassified as Category C following his review.

### **Healthcare Waiting Area**

Mr D complained about the cleanliness of the Maghaberry Healthcare waiting area, and about other prisoners being allowed to smoke in the Healthcare holding room. In response the Governor made arrangements for the area to be cleaned regularly. Mr D acknowledged this addressed the issue of cleanliness, but re-complained as he said other prisoners continued to smoke in the holding room.

Governors Order 19-10 outlines the NIPS Smoking Policy: it “...provides for most enclosed and substantially enclosed public places and workplaces to be smoke-free.” Holding rooms are enclosed public places and therefore should remain smoke-free. Indeed it is against the law to allow smoking in confined public spaces.

We therefore upheld this complaint and made two recommendations relating to the need for staff and prisoners to adhere to the policy, and specifically for staff to ensure that the policy is enforced. The NIPS accepted our findings and recommendations.

### **IPC Account**

Mr E complained about money going missing from his personal account. He said members of his family had left £385 in for him during a visit and were given a receipt. However the NIPS later told him that a mistake had been made by the officer who took the money and only £285 had been received. Mr E disputed this as the money was counted in the presence of his visitors before the receipt was issued.

Mr E said neither he nor any member of his family were notified of the discrepancy by the NIPS, and he only became aware of it a few days later when he asked for a copy of his Inmate Private Cash account. He provided the original receipt which had been given to his visitor. It showed that £385 was received by the NIPS, and on the same day £100 was taken out and recorded as ‘Error Out.’

The NIPS did not dispute that Mr E’s visitor was given a receipt for £385, and was unable to provide any evidence to support their assertion that the cashier made a mistake when recording the amount received. We concluded that, although it is possible a mistake was made, the purpose of providing receipts is for both parties to have proof of the transaction. It was therefore inappropriate to dismiss the validity of the receipt without evidence that it was provided incorrectly. In the absence of such evidence we upheld the complaint and recommended that the NIPS should honour their receipt for £385 and credit the prisoner’s account with the remaining £100. The NIPS accepted the recommendation and subsequently credited Mr E’s account with £100.

### **Withdrawal of Ceramic Cups**

A number of prisoners complained about withdrawal of ceramic cups from sale in Maghaberry Tuckshop. This decision was based on a review which the NIPS undertook following “several attacks by prisoners on prisoners and prisoners on staff.”

We requested a copy of the review but the Prison Service did not have a written record. They suggested there were five incidents since 2012. The circumstances were not known so it was impossible to establish their seriousness or whether ceramic cups were actually used as weapons.

Significantly the NIPS did not consider it necessary to remove the numerous ceramic cups which were already in prisoners' possession. This called into question the level of assessed risk, as many potential weapons would still be in circulation. We also pointed out that prisoners possess other items, such as flasks, which could be used as weapons. Therefore unless all such items are confiscated, the decision to withdraw ceramic cups from sale appeared to be disproportionate.

We upheld the complaint and recommended that the decision to withdraw ceramic cups from sale be rescinded. The NIPS accepted this recommendation.

### **Legal Papers**

Mr F complained that his confidentiality was breached when staff removed papers from an envelope which was marked as "Legally Privileged."

The search record stated the papers were removed as they were not legal papers. However there was no record of how that decision was made. In addition Standing Order 5.3.5 states that "*Correspondence shall be withheld from the prisoner only on the direction of the Director of Operations at NIPS HQ or his authorised representative.*" We therefore concluded that it was not appropriate for local staff to determine that legal privilege applies to some papers and not others.

We upheld this complaint and made two recommendations relating to the proper application of SO 5.3.5. These were accepted by the Prison Service.

### **Access to Sanitation**

Mr G complained that when he had been unlocked over lunchtime to use the ablutions, he had filled a basin of water to bring back to his cell. However an officer told him to put the basin back in the ablutions and as result he had no water to wash his hands.

His complaint was upheld with a recommendation for staff to be reminded that all cells should be equipped with a hand basin and a supply of water prior to planned lockdowns. The NIPS accepted this recommendation and Notice to Staff 34/13 was re-issued.

### **E-cigarettes**

Mr H complained that he was unable to purchase an electronic cigarette through the tuckshop. The Prison Service responded by saying "*E-cigarettes are not permitted within the NIPS due to the fact that they contain circuitry and require use of a concentrate of Nicotine solution. Should you wish to cease smoking, Healthcare will provide advice and alternative means of doing this through the use of Nicotine patches.*"

We learned that Guernsey Prison had commissioned a report from the State Analyst's Laboratory on a product called E-Burn. It concluded that E-Burn met their

security specifications, and after a successful trial, Guernsey Prison had made it available for prisoners to purchase.

We upheld this complaint and recommended that the NIPS should conduct similar trials on entry level, disposable, sealed-unit E-cigarettes with a view to making them available through the tuck shop. However the NIPS did not accept this recommendation in the absence of regulation of electronic cigarettes.

### **Adjudications**

We investigated a number of complaints about the adjudication process. These highlighted that the NIPS does not have a clear policy regarding appeals against adjudication outcomes. Information Sheet 21 sets out how an appeal can be made: through a legal adviser or by submitting a complaint via the NIPS Internal Complaints Procedure and onwards to the Prisoner Ombudsman.

There are a number of difficulties with this process: it does not make clear that lodging a complaint will be treated as an appeal; no information is provided regarding how, or by whom, an appeal will be considered; and no time limits are given. In addition, adjudication decisions are routinely reviewed in the first instance by the original decision-maker, which is a flawed process.

We upheld the complaints and recommended the NIPS should promptly develop a clearer policy regarding adjudication appeals. This recommendation was accepted.

### **Access to Rehabilitation Programmes**

Mr I complained that he would not have sufficient time to complete the required rehabilitation programme in order to be eligible to be considered for parole.

We upheld his complaint and recommended the NIPS should make every effort to provide sufficient programmes to meet demand. In cases when this did not happen, the NIPS should explain their reasons for failing to provide programmes to the Parole Commissioners.

The NIPS accepted the recommendation and said it would be taken forward by their Psychology Service. They also said Mr A would be referred to a programme as soon as possible.

### **Correspondence with Statutory Bodies**

Mr J complained about the rule governing confidential correspondence applying only to legal representatives. The Prison Service's response reiterated this position.

The NIPS response was incorrect as there are a number of other bodies with whom prisoners can correspond confidentially. We upheld Mr J's complaint and recommended the NIPS should amend Standing Order 5.7.1 to allow confidential access by a prisoner to a range of other bodies including elected representatives, the Law Society, Bar Council, Criminal Justice Inspection and Independent Monitoring Board. The NIPS accepted this recommendation and undertook to review the Standing Order.

## Deaths in Custody

### *The Prisoner Ombudsman initiated investigations into two deaths in custody and four post-release deaths.*

Ombudsman investigations into prison deaths are part of a three-pronged process (the other elements being a police investigation and the Coroner's inquest) by which the state fulfils its duty under Article 2 of the European Convention on Human Rights. This process allows every aspect of a prisoner's death to be thoroughly explored.

There were no deaths in Magilligan, Hydebank Wood or Ash House during the year and both of the new investigations involved Maghaberry prisoners. One appeared to be self-inflicted and the other appeared due to natural causes. Definite causes of death await post-mortem results.

Each post-release death was subject to a preliminary investigation to establish whether there was any link to the person's time in custody. Post-mortem results and toxicology tests to date have not shown any such link. Rather it was apparent that in each of these deaths the prisoners had been well-prepared for release, but had subsequently been unable to sustain abstinence in respect of pre-existing drug and alcohol problems.

Newly-released prisoners are recognised as a vulnerable group, at particular risk of untimely death due to substance misuse. Eleven post-release deaths were reported to my office between June 2013-March 2016. Table 6 outlines the main details.

**Table 6 Post release death investigations June 2013 – March 2016**

Establishment	Days since release	Apparent Cause of Death	Type of Investigation	No of Recs of
HBW	1	Drugs overdose	Desktop	0
MGN	10	Drugs overdose	Desktop	0
MBY	2	Drugs overdose	Desktop	0
MGN	Same day	Heart attack	Desktop	0
MGN	4	Drugs overdose	Desktop	0
MBY	53	Brain tumour	Full / Published	15
MBY	3-6	Acute alcohol intoxication	Desktop	0
HBW	9	Drugs overdose	Desktop	7
MGN	4	Drugs overdose	Desktop	0
MBY	3	Heart attack + cocaine usage	Desktop	0
MBY	1	Drugs overdose	Desktop	8

The majority of the recommendations in these cases were procedural, relating to care plans, record keeping, communication, medication management, committal procedures and discharge arrangements.

One death in custody investigation, six post-release deaths and one serious incident investigation were finalised during 2015-16; and we published three reports. Forty-two

recommendations (17 NIPS & 25 SEHSCT) were made and accepted in three of the investigations.

On 31<sup>st</sup> March 2016 we had five DiC investigations and three post-release investigations ongoing.

Delays in obtaining material from the NIPS and SEHSCT and in receiving factual accuracy responses to draft reports were inordinate and longer than last year. The Trust explained the delays were due levels of non-direct requests which impact on clinical capacity, and explained it must prioritise direct patient care and also complete its own investigations to meet statutory requirements and Department of Health policy. While I recognise the Prison Service's and the Trust's operational priorities, it is important that this situation improve if the benefits of publicly-funded prison oversight are to be fully delivered.

## Comparisons

There were 76 apparent self-inflicted deaths in English/Welsh prisons during 2014-15, a 16% decrease on the previous year. Natural causes deaths however increased by 15% and there were also four homicides<sup>5</sup>.

22 people died in 2015 while in the custody of the Irish Prison Service or while on temporary release. This compares to 14 each for 2014 and 2013.<sup>6</sup>

The September 2015 "Safer in Custody Statistics" are informative: *"The prison population is very different from the general population: 95% of the population are male, there are no prisoners aged under 15 and relatively few are over 60. As a result, rates of deaths in prison custody cannot be compared directly with those for the general population. One technique used for comparing mortality rates for different populations is known as the Standardised Mortality Ratio (SMR)... It showed in 2015 that the likelihood of prison mortality in England & Wales was 45% greater than in the general population."*<sup>7</sup>

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<sup>5</sup> [http://www.ppo.gov.uk/wp-content/uploads/2015/09/PPO\\_Annual-Report-2014-15\\_Web-Final.pdf#view=FitH](http://www.ppo.gov.uk/wp-content/uploads/2015/09/PPO_Annual-Report-2014-15_Web-Final.pdf#view=FitH)

<sup>6</sup> <http://www.irishtimes.com/news/crime-and-law/numbers-of-prisoners-dying-rose-to-22-in-2015-1.2656950>

<sup>7</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/495665/safety-in-custody-statistics-september-2015.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/495665/safety-in-custody-statistics-september-2015.pdf)

### External Communication

*The Prisoner Ombudsman maintained a wide range of external communication during 2015-16.*

Publication of each DiC report and the 2014-15 Annual Report were accompanied by a press release and where appropriate, supplementary communications activity.

The Ombudsman maintained contact with relevant bodies during the year. These included the Coroner's Service, the Parole Commissioners, the Regulation & Quality Improvement Authority, the Northern Ireland Assembly Ombudsman, Criminal Justice Inspectorate, International Committee of the Red Cross, South Eastern Health & Social Care Trust, Public Health Agency, Prison Officers Association, British-Irish Intergovernmental Secretariat, Prison Review Team Oversight Group and HM Inspectorate of Prisons.

He addressed the Independent Monitoring Boards 2015 annual general meeting, contributed to the Ministerial Forum on Safer Custody and met visiting delegations from the Turks & Caicos Human Rights Commission and the Bahrain National Institution for Human Rights.

The Prisoner Ombudsman met local political representatives in relation to the statutory footing process; and held a monthly stocktake with the NIPS Director-General and quarterly stocktakes with each prison governor. He was a regular visitor to the prisons, where he met prisoners individually and collectively. He also met with prisoners' families.

"*Inside Issues*," a four page newsheet, was the Prisoner Ombudsman's main vehicle for communicating with prisoners. It included case studies, statistics and information about the complaints process in eight languages. Summer and Winter 2015 editions were published and a copy distributed for each person held in NIPS custody at the time.

### Finance

*The DOJ Internal Audit Unit Finance & Governance Audit 2015-16 provided a "Substantial" level of assurance.*

The Prisoner Ombudsman's budget for 2014-15 was £579,000. The 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 with the DOJ. They place 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;
- 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's Office 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's office 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. 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 ending 31<sup>st</sup> March 2016, 94% were paid within the 10-day timeframe.

The annual Finance and Governance report by the DOJ Internal Audit Unit found the Prisoner Ombudsman's performance provided "*Substantial Assurance*" and did not make any recommendations.

In September 2015 the DoJ sponsor branch proposed that their quarterly overview meetings with the Prisoner Ombudsman's Office be reduced in frequency to biannually, on the basis that they were content with levels of assurance in place. This was agreed.

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 evaluation takes place.

## Information Security

### *Information Security is 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.

## Risk Management and Internal Control

*A number of risks were re-evaluated during the year and the Risk Register was updated in March 2016 to reflect the priorities.*

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

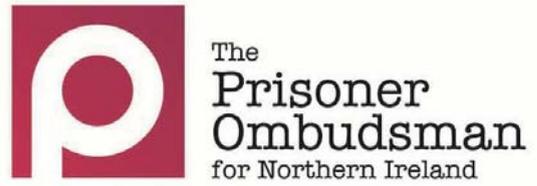
## Shared Services

*Several 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 the NICS 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.



[www.niprisonerombudsman.gov.uk](http://www.niprisonerombudsman.gov.uk)

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