The Prisoner Ombudsman for Northern Ireland

PRISONER OMBUDSMAN FOR NORTHERN IRELAND

ANNUAL REPORT 2014-15

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FOREWORD

I am pleased to present my second Annual Report which covers the period April 2014-March 2015.

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

Our work is entirely demand-led, which means volumes are unpredictable. During 2014-15 we commenced investigations into three deaths (one less than last year), two serious self-harm incidents in custody and five post-release deaths. The situation was not as alarming as in England and Wales where there was a 64% increase in self-inflicted deaths in prison.

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 as required under Article 2 of the European Convention on Human Rights. This process allows every aspect of a prisoner's death to be thoroughly explored.

We received 1,429 eligible complaints, triple the 2013-14 figure. Separated Republican prisoners in Maghaberry accounted for 81% of these complaints. A 27% reduction in complaints received from integrated prisoners does not reflect the true position - rather it appears due to Maghaberry's internal system being under considerable pressure and prisoners were therefore unable to process many eligible complaints to our office. This is regrettable as a prison is more likely to maintain equilibrium if prisoners feel they have an accessible and effective outlet for their grievances and confidence that their complaints will be considered properly, with reasons given for decisions.

The four year programme to deliver fundamental reform of the Prison Service which concluded in March 2015 generated several initiatives to improve prisoner wellbeing. In doing so they also addressed issues that formerly led to complaints. These included cessation of automatically handcuffing prisoners during transportation and fewer prisoners being accommodated in Maghaberry's older houses.

Increased finds of illicit drugs has been a positive result of targeted searching as abuse of "legal highs" and prescribed medication by prisoners has become a major concern. Efforts to provide predictable regimes were generally successful in Hydebank Wood Young Offenders Centre, Ash House Women's Prison and Magilligan Prison. Greater freedom of movement within Ash House and significantly increased levels of off-landing activity in Hydebank Wood also helped.

However high levels of staff unavailability at Maghaberry Prison were a serious problem during 2014-15. The consequences included unpredictable and restricted regimes, long periods of unscheduled cellular confinement and limited purposeful activity, all of which heightened tensions and increased frustration and vulnerability levels among prisoners. This is fundamentally at odds with the reform agenda and risks destabilising the prison. It is therefore imperative that, while

avoiding complacency at the other prisons, the NIPS must take urgent remedial action at Maghaberry.

Within this context we worked to undertake impartial and thorough investigations which balanced prisoners' experience with official perspectives. The complaints we received ranged from minor matters that should have been locally resolved, to serious complaints about staff attitudes and conduct.

We made 137 recommendations for improvement in relation to complaints and 83% of these had been accepted at the time of writing. We recommended a stocktake should be undertaken of the agreement that was reached in August 2010 between separated Republican prisoners and the NIPS. This was done by a group of independent assessors though it did not resolve things.

We made 78 recommendations for improvement in death in custody reports, all of which were accepted by the NIPS and the South Eastern Health & Social Care Trust (SEHSCT). Most of the areas for improvement arose when the NIPS and SEHSCT did not correctly follow their own procedures and the impact of staff shortages was also apparent.

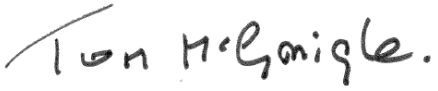
The Prisoner Ombudsman's Office is neither empowered nor resourced to enforce accepted recommendations, which can sometimes be a source of frustration for prisoners. In November 2014 I wrote to the Minister of Justice and the Minister of Health to express concern about the need to repeat recommendations that had previously been accepted in death in custody reports. Both Ministers replied in positive terms and I expect to see an improvement in this situation.

The process of placing my office on a statutory footing continued. This was led by the Department of Justice and their proposal was accepted by the Justice Committee of the Northern Ireland Assembly in June 2014. Legislation was drafted and it is hoped this will be enacted by the end of the current Assembly mandate in May 2016.

I continue to encourage the prison reform process in Northern Ireland, but am concerned about the impact of budget cuts. Any reduction in services or opportunities for prisoners to use their time productively will only increase the negative consequences of detention for them, their families and for the community.

Budget cuts will also impact on my Office in 2015-16. I will continue to prioritise the investigative function, but delays in meeting investigative timeframes will be inevitable if the Office's resources reduce further.

I am grateful to all who supported our work, especially everyone in my Office for their contributions to an important public service during 2014-15.



Tom McGonigle
Prisoner Ombudsman for Northern Ireland

June 2015

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.

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.

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

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

Draft DiC reports are shared with the NIPS, SEHSCT and the next of kin; and final reports are also sent to the Minister of Justice and the 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 DiC 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 people 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

Principle 1 - INDEPENDENCE

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

Principle 2 - PROFESSIONALISM

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

Principle 3 - SERVICE-ORIENTATION

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

Principle 4 - CLEAR COMMUNICATION

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

Principle 5 - EFFICIENCY

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

Principle 6 - FORWARD LOOKING

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

Organisational Structure and Responsibilities

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

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 the South Eastern Health and Social Care Trust which is responsible for providing healthcare to prisoners. For corporate governance purposes the Prisoner Ombudsman's Office is treated as an Advisory Non-Departmental Public Body.

Corporate governance is delivered through quarterly formal meetings with the sponsoring Division of the DOJ (Policing Policy & Strategy Division/Probation and Prisoner Ombudsman Unit), 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 Prisoner Ombudsman's website. The Director of Operations is responsible for ensuring that the Prisoner Ombudsman's policies and actions comply with DOJ rules and processes and for managing the resources allocated to the office efficiently, effectively and economically.

Staffing

On 31st March 2015 the staff complement comprised 11.1 posts/12 people:

Prisoner Ombudsman (4 days per week)
Director of Operations
2 x Senior Investigators (1 @ 30 hrs per week)
5 x Investigators; and
3 x support staff (1 part-time)

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

Staff undertook the full range of Northern Ireland Civil Service (NICS) required training during 2014-15. This was delivered online, and included Data Protection responsibilities, Government Security Classifications, Office Safety and Fire Prevention. Team briefing events included the statutory footing process, NIPS Professional Standards Unit, Safety of Prisoners, and the Conditional Early Release Scheme.

A new Investigator spent three days with the NIPS as part of his 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 2014-15 operating budget was £574k, 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.

The office was subject to a 5% cut in budget during the year. This was achieved by not replacing a part-time Personal Secretary who transferred and by delay in replacing an Investigator.

Further financial efficiency is required in 2015-16. As the priority is to preserve the office's investigative function, this may require alternative ways of fulfilling administrative and governance responsibilities.

Corporate and Business Planning

A Corporate Plan for 2014-17 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 2014-15

- **Investigations initiated into the deaths of three prisoners and five ex-prisoners**
- **Completion of five DiC investigation reports**
- **1,429 complaints received, an increase of 318% from 2013-14, the bulk of which came from Roe 3&4 prisoners**
- **27% reduction in complaints from integrated prisoners**
- **97% of all complaints (86% excluding Roe 3&4) came from Maghaberry**
- **137 recommendations for improvement made in complaint reports, of which 83% had been accepted at the time of writing**
- **78 recommendations for improvement in DiC reports, all of which were accepted.**

Other Operational Headlines for 2014-15

- **The statutory footing process continued.** The Department of Justice proposal to place the Office on a statutory footing was accepted by the Justice Committee of the Northern Ireland Assembly in June 2014 and legislation was drafted which it is hoped will be enacted by the end of the current Assembly mandate in May 2016.
- **Staffing remained relatively stable** for the duration of the 2014-15 year: an Investigator who resigned in April 2014 was not replaced until September 2014; a Senior Investigator retired in May and was replaced in June 2014; and a part-time PA transferred within the NICS in August and was not replaced.
- **We redrafted the Terms of Reference for Complaints and Deaths in Custody.** Finalisation of this process was postponed to ensure the Terms of Reference will be compatible with the Rules that are due to accompany statutory footing.

Performance against targets 2014-15

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

The outcomes for 2014-15 objectives were as follows:

1. Statutory Footing

1. Identify and address implications with prisoners, their families, NIPS, SEHSCT and other relevant bodies

   Achieved – The DoJ and NIPS arranged for a copy of the consultation to be placed on each landing and in the Prison Visitor Centres, issued an explanatory letter to every prisoner, and provided translations for foreign national prisoners.

2. Scope and address the implications for current Prisoner Ombudsman staff.

   Achieved via a meeting with DoJ officials in May 2014 and in ongoing discussions.

3. Identify issues to be included in the legislation and supporting regulations.

   This was done via staff meetings and e-mail feedback. Drafts of the legislation were considered at management meetings and with the staff group.

4. 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 legislation - was not established during 2014-15. However the Prisoner Ombudsman and Director of Operations were closely involved in developing the legislation.

2. Complaints and DiC Investigations

1. Produce investigation reports which are evidence-based and impartial.

   Opinions about report quality are often subjective, especially if the evidence is inconclusive. However no formal complaints were lodged about the quality of our investigations or reports. When informal challenges were mounted we reviewed the evidence to ensure adherence to the Rules and Terms of Reference.

   A "Lessons Learned" process was introduced to evaluate all DiC investigations and reports, as well as significant complaint investigations and reports. This has been a useful quality control mechanism.

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 indicated compliance with the Terms of Reference, especially the important principles of evidence-based and impartial practice.

   The process for anyone who wants to complain about our practice dates from inception of the Office. It is not user-friendly and we have therefore set an objective for 2015-16 to commission an independent, external review of our investigation and reporting practices. If commissioned, this review will be helpful in highlighting areas for improvement and recognising good practice.

3. Adhere to timescales (nine months for draft DiC reports, and 18 weeks for final Complaints reports) in all investigations.

   Partially achieved: 70% of cleared complaints were sent to the NIPS for factual accuracy check within 12 weeks. Of the eight DiC investigations sent for factual accuracy check, three were sent within the nine month target, one was one month overdue, two were five months overdue and two were six months overdue.

   Lack of access to evidence and unavailability of staff for interview were the main reasons for underachievement of timescale targets. Both of these matters are beyond our control.

4. Ensure an Investigator is on site within four hours of being notified about a death in custody.

   Achieved.

5. Review appropriateness of the above timescales.

   We reviewed the four hour target and concluded it should be retained.

6. Update Complaints and DiC Terms of Reference.

   Drafting commenced but this process can only be completed in conjunction with the DoJ, NIPS and SEHSCT after statutory footing has been decided.

7. Identify opportunities to reduce the length of time taken to complete Complaint and DiC investigations and associated reports.

   Current format DiC reports show a 66% reduction in length from previous versions but investigations remain thorough and no key analysis has been lost. Indeed the messages can be even more apparent in a shorter report and we have received positive feedback from families, the NIPS and SEHSCT about this approach.

8. Develop a suitable DiC database.

   A new database which was introduced in March 2015 allows better analysis of DiC trends e.g. by location and prisoner profile.

9. Update the Complaints Database.

Achieved. The new version provides better management information e.g. in relation to the main causes and locations of complaints, categories of complainant and cases suitable for triage. However work to update the database remains ongoing as there is a significant administrative burden in processing complaints.

10. Agree with the NIPS a mechanism for monitoring implementation of accepted recommendations.

We undertook a dip sampling exercise with the NIPS in November 2014. The analysis showed that a number of recommendations which were recorded as outstanding were due to factors that lay outside the NIPS control. We will continue to work with the NIPS to reconcile and verify implementation of recommendations.

As with other areas of work, monitoring of recommendations has been manageable at Hydebank Wood and Magilligan, but problematic at Maghaberry due to the volumes involved.

11. Review arrangements for investigating complaints about Probation services within prison.

We were advised that complaints against PBNI have been subject to investigation by the Northern Ireland Assembly Ombudsman since Justice was devolved in April 2010. It was therefore agreed that the pilot project with PBNI should conclude as it would be inappropriate to have two separate investigations into the same complaint.

12. Ensure low user groups - foreign national prisoners, young offenders and visitors - understand the role of the Prisoner Ombudsman and are able to access our services.

We continued to address underuse of our service by certain prisoner groups. Efforts this year included establishing a bi-monthly "clinic" at Hydebank Wood for young male prisoners and contributing to forums for foreign national prisoners at Maghaberry. While the numbers of formal complaints from low users has not increased, we have identified several local concerns and achieved prompt responses from prison managers.

13. Refine the "Initial Information Gathering" function in connection with complaints received.

Loss of experienced personnel and large volumes of complaints forced us to review the administration of initial stages of complaint handling. The changes introduced to date have enabled us to work more effectively with fewer staff.

14. Review the operating hours of the Office Freephone service.

We conducted this review in October 2014 and decided to retain the current Freephone operating times. We also introduced a Freepost service in April 2014 on a pilot basis.

3. Support for NIPS Complaints Handling

1. Assist the NIPS to improve local resolution of complaints. In Year 1 this will include establishment of a baseline to enable future comparisons.

   We established a baseline of 58 cases per year, based on 2013-14 figures. 22 cases were referred for triage between April 2014-March 2015 and a further 143 were locally resolved during the same period following our intervention.

2. Contribute to relevant consultation exercises, conferences and other events to share the findings of Complaint and DiC investigations.

   The Prisoner Ombudsman contributed to the Ministerial Forum on Safer Custody and was actively engaged in developing the statutory footing legislation. He raised concerns with the Minister of Justice and the Minister of Health in November 2014 about the need to repeat DiC recommendations that had previously been made and accepted by the NIPS and the SEHSCT.

   The Ombudsman gave interviews to local broadcast and print media about topics that included Death in Custody publications, the 2013-14 annual report, repeated recommendations and substance misuse in prisons.

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 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 all these bodies throughout the year and with others such as the Dáil Éireann ad hoc group on prisoners and the International Committee for the Red Cross.

3. Contribute to the training of NIPS staff if requested.

   The Ombudsman and Director of Operations contributed to training for NIPS Senior Officers and middle managers. Two temporarily-promoted Senior Officers visited the office to learn about our approach to investigation.

4. Issue two editions of *"Inside Issues"* magazine to prisoners.

   Inside Issues was prepared and circulated in July 2014 and December 2014.

5. Engage with other government departments to support policy-making that assists prison reform.

   We agreed to an extension of 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.

We received 1,429 eligible complaints, 318% more than last year, the bulk of which came from separated Republican prisoners. There was a reduction of 27% in complaints received from integrated prisoners.

Context

Independent investigation of complaints can help instil in prisoners greater confidence that their welfare is treated seriously and can help reduce tension and promote better relations. The NIPS Internal Complaints Process (ICP) is underpinned by prisoners' right to lodge a complaint. While anecdotal evidence suggests that prisoners have mixed views about the effectiveness of the ICP, there would appear to be no general reluctance on the part of the adult male population to submit complaints. NIPS data for April 2014 – March 2015 shows:

9,456 complaints were made, of which:

- 5,340 (56%) were closed at Stage 1
- 1,637 (17%) were closed at Stage 2
- 6% were closed upon the prisoner's release
- 21% were still open at the end of the year

When the separated Republican prisoners' complaints (2,298 from prisoners on Roe 4 and 727 from Roe 3) are removed from the equation, the number of complaints made by other prisoners (6,431) was virtually identical to the previous year (6,428).

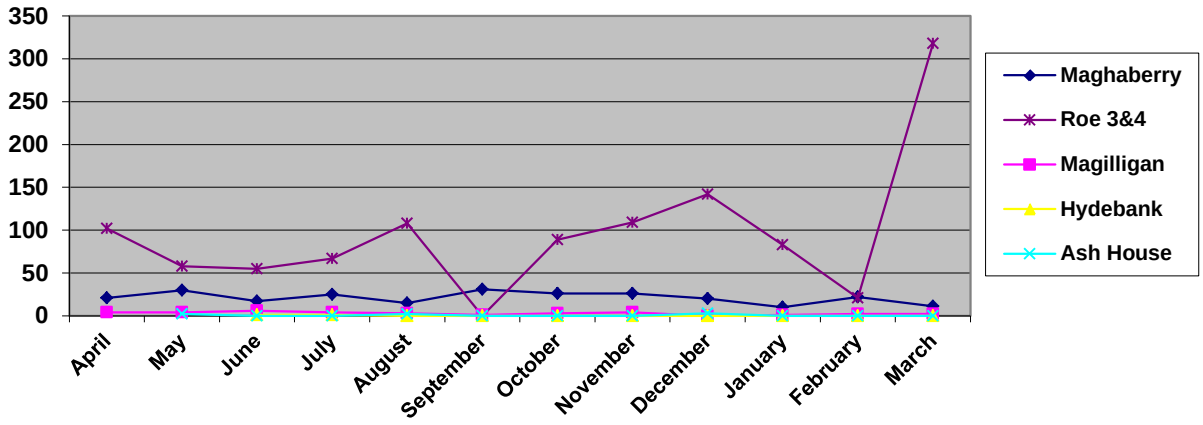
There are various reasons for complaints being closed. These range from prisoners receiving a reasonable answer, through to being discharged from custody or abandoning their complaint. Part of the explanation is however a failure to effectively deal with complaints at the first or second stages. This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

During the year we found that a large number of complaints were either not answered at Stage 2 at all, or that the Stage 2 response simply reiterated the response that was given at Stage 1. Neither approach instils confidence in prisoners that they are being treated seriously.

Complaints only become eligible for investigation by our office after Stages 1 and 2 have been exhausted; and prisoners 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 instruct law firms in Judicial Reviews.

Figure 1 and Table 1 illustrate that 97% of complaints to our office came from Maghaberry Prison. When separated Republican prisoners' complaints are removed from the equation, Maghaberry's rate (86%) is 4% higher than last year. Like young men in custody throughout the UK, Hydebank Wood prisoners made little use of the official complaints system and complaints from the women prisoners in Ash House were proportionate to their numbers. Magilligan's overall total was low and less than last year, reflecting the more stable population held in that prison and an increased emphasis on local resolution before complaints were escalated to us.

Figure 1 - Eligible Complaints Received by Establishment April 2014 - March 2015



Roe 3&4

At the beginning of 2014 the separated Republican prisoners on Roe 3&4 landings of Maghaberry Prison began to lodge large volumes of complaints. They routinely refused to accept NIPS responses at Stages 1 and 2 and by the end of the year the Roe 3&4 prisoners, who comprised 2% of the total prison population, had made 81% of the eligible complaints received by our office. Nearly all of these were presented as multiple, identical iterations of various grievances. Roe 4's rate of complaints remained consistently high throughout the year but the rate from Roe 3 was much lower and declined significantly from late 2014 onwards.

The complaints included issues such as timing and duration of alarm tests, frequency of night checks, access to printers and proposed changes to visiting arrangements. However the prisoners' main concerns involved controlled movement, full body searching and refusal of permission for some prisoners to enter separated conditions.

It was agreed with the prisoners and with the NIPS that we would group these complaints in order to reduce investigative and administrative pressures.

In response to a batch of complaints we recommended in May 2014 that a stocktake of the August 2010 Agreement should be undertaken, as that agreement provided the best opportunity to resolve the longstanding tensions between separated Republican prisoners and the NIPS. The recommendation was accepted by the prisoners and by the NIPS.

The stocktake was undertaken by a group of independent assessors and published in December 2014. The assessors recommended that the prisoner forum - which was intended to convene regularly and address issues of concern - should be reinvigorated, with an independent chairperson. However the forum did not convene because of disagreement about appointment of the chairperson. It is therefore increasingly difficult to offer creative solutions to complaints received from separated Republican prisoners.

While we investigated and reported on separated Republican prisoners' complaints in line with the Rules and Terms of Reference and in the same way as all other complaints, Roe 4 prisoners repeatedly requested that we exceed our remit. We were asked to support campaigns for named staff to be removed from Roe 3&4, intervene in disputes with the

NIPS on their behalf and accept new elements to complaints after the NIPS had provided its responses. Our duty of impartiality and independence meant it was not possible to accede to these requests. This was communicated to the prisoners on several occasions but they continued to express frustrations in this regard.

Integrated Prisoners

276 complaints made by integrated prisoners were escalated to our office. This represented 4% of all the complaints that prisoners initiated and represents a significant reduction (from 380) in their complaints being escalated to us. We also received 400 ineligible complaints.

There has been a significant drop in the prison population since last year: there were 800 fewer committals and the actual population was 198 lower on 3rd April 2015 than on 3rd April 2014. However as integrated prisoners initiated the same number of complaints to the NIPS as last year, the lower population does not explain the reduction in complaints being escalated to us.

Lack of capacity in Maghaberry appears to be the main cause. Some 1,500 complaints, equally divided between separated Republicans and other prisoners, were stuck within the Internal Complaints Process (ICP) at the end of March 2015. The ICP was under considerable pressure from Roe 3&4 complaints and therefore unable to process outstanding complaints, some of which would be eligible for escalation to our office.

Other, more positive explanations for the reduction in complaints being escalated to us include increased informal and local resolution, fewer prisoners held in Maghaberry's older accommodation and removal of the requirement to automatically handcuff prisoners during transportation. Training for NIPS managers in complaint-handling and Magilligan's focus on addressing complaints at local level may also have assisted.

Table 1 – Eligible Complaints Received April 2014 – March 2015

Location	Total	Percentage of all complaints	Percentage of complaints excluding Roe	Percentage of overall prison population on 31 March 2015
Roe 3&4	1,153	81%	-	2%
Maghaberry Others	235	16%	86%	56%
Magilligan	32	2%	12%	31%
Hydebank Wood	2	-	-	7%
Ash House	7	-	2%	4%
Overall Total	1,429			

Table 2 – Maghaberry Eligible Complaints Received by location April 2014 – March 2015

Location	Number of Complaints
Bann	10
Braid	28
Bush	22
CSU	46
Erne	43
Foyle	9
Lagan	22
Moyola	2
Quoile	23
Released	7
Roe 1&2	14
Roe 3&4	1,153
Shimna	4
Visitor	2
Wilson & Martin	9

Significant points from Table 2 include:

- Some Care & Support Unit complaints related to events that led to prisoners being housed in the CSU, rather than arising while they were there;
- The low complaint rate from Bann House may be explained by its role as the committal house, where most prisoners spent only a short period. Many were in custody for the first time and therefore unfamiliar with the complaints process.

Table 3 – Integrated Prisoners Main Complaint Topics 2014-15

Complaints Topic	2014-15	2013-14	2012-13
Property and Cash	35	48	43
Visits	10	46	24
Staff attitude	35	46	36
Accommodation	43	41	7
Adjudications	6	15	4
Mail	3	21	7
Searching	13	21	9
Transfers	12	19	17
Health & Safety	0	18	6
Access to regime	4	15	19
Home leave	7	15	15
Lock down	12	14	22
Discrimination	3	13	16
Education	9	12	5
Adverse reports	5	10	4
Miscellaneous	79	96	163
TOTAL	276	450	407

"Miscellaneous" complaint categories include lack of Offending Behaviour Programmes, night time monitoring of prisoners, Passive Drug Dog indications and work allocation.

Table 4 – All Prisoners cleared complaint outcomes April 2013 – March 2015

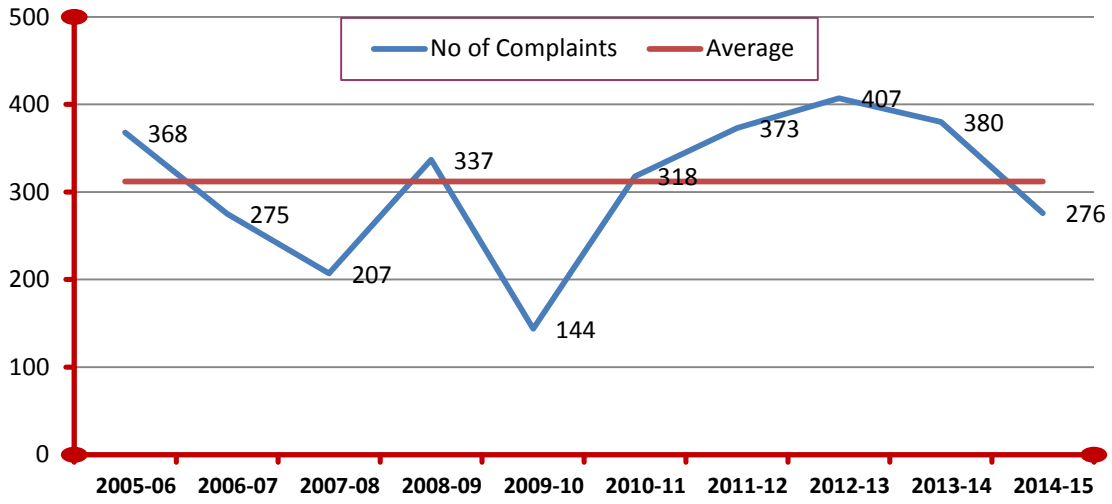
	Upheld	Not Upheld	Partially Upheld	Local Resolution	Withdrawn	Total
2014-15	473 (44%)	227 (21%)	173 (16%)	143 (14%)	52 (5%)	1,066
2013-14	216 (46%)	136 (29%)	26 (6%)	58 (12%)	32 (7%)	468

We made a total of 137 recommendations for improvement in response to prisoners' complaints during 2014-15. At the time of writing 83% of these had been accepted.

Comparisons

Table 5 indicates that complaint trends have been erratic over the years. However this data needs to be treated with caution as different recording methods were used in the past: 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.[1]

Table 5 - Eligible Complaints Received 2005-15 (excluding Roe 3&4)



By way of comparison, complaints to the Prisons & Probation Ombudsman for England & Wales reduced by 9% in 2013-14 from the previous year. He upheld 34% of complaints, up from 23% in 2011-12.

The Scottish Public Services Ombudsman fully upheld 32% of prison complaints in 2013-14, compared with a 50% rate across all other sectors that he oversaw.

[1] The Prisoner Ombudsman however still investigates the Healthcare dimension of Deaths in Custody.

Complaint Case Studies

Besides illustrating specific complaints that reached our office, it is also important to identify issues we heard about from prisoners that were never formally raised. Prisons are dominated by rules and the way staff interpret the rules is very important. For example we heard of a ring binder being denied to a prisoner. It was requested to hold sheet music and another prisoner living in the same area already had two ring binders for that purpose. A second prisoner was refused permission to have a family photograph because it contained an image of a pint of beer. Neither of the prisoners involved made a formal complaint, but they were understandably frustrated by staff interpretation of the rules.

Integrated prisoners at Maghaberry complained about the adverse impact of separation on their lives. When staff were withdrawn from their landings to provide the high ratios required for separated houses they were subject to extended periods of lockdown and there were many delays e.g. in processing their requests, mail and complaints. They also held a perception that the separated population received preferential treatment.

Some of the complaints we received involved the NIPS efforts to improve living conditions for prisoners. For example women in Ash House complained about a lengthy period of disruption due to construction work that ultimately delivered an improved facility.

We received several unconnected complaints about the heating system at Maghaberry. These caused undoubted discomfort to prisoners but could not be upheld on the basis that the cell temperatures were within established parameters.

Complaints about regime restrictions were a particular theme at Maghaberry throughout the year and the situation deteriorated as time went on. Hydebank Wood, Ash House and Magilligan coped with reductions in staff but the impact of shortages, mainly due to high rates of sick leave, was acutely felt at Maghaberry. There were an average of 56 partial lockdowns per month there during January-December 2014, which was particularly concerning when abuse of "legal highs" and prescribed medication were also increasing.

Failed Drugs Test

Mr A complained about regime demotion following a failed drugs test, the results of which he disputed as he maintained he had only taken prescribed medication. Residential officers and medical staff were surprised at the result, given Mr A's positive history. However the test was recorded as a fail during his adjudication.

Our investigation found evidence to suggest that Mr A failed the drugs test as the result of other factors and not due to illicit drug use. We recommended the failed test should be expunged from his record. While the Prison Service was initially unwilling to amend Mr A's records, the recommendation was ultimately accepted and the reference to a failed drugs test was removed from his record.

Adjudication

Mr B felt the proper procedure had not been followed during his adjudication.

Examination of the documentation and audio recording of the adjudication revealed a number of deficiencies: a statement was not made available to Mr B despite a previously accepted Ombudsman recommendation that this should be done; he did not receive adequate opportunity to advance his argument of self-defence; the issue of witnesses was not dealt with until after he had been found guilty; and the Adjudicating Governor admitted contested evidence from a third party after he had left the room.

We recommended the adjudication should be quashed and that all Adjudicating Governors be reminded of the need to adhere to the Adjudication Manual. The NIPS accepted both recommendations.

We also noted that the procedural deficiencies of the adjudication should have been readily-apparent during the NIPS internal investigation of this complaint. If this had been done, the matter could have been locally resolved.

Privileged Mail

Mr C complained about the treatment of his legal mail during a cell search. He had been advised at Stage 1 of his complaint that his legal papers would have been searched but not read. He said that he had not been given an opportunity to identify and take his legal mail with him during a cell search and that his correspondence had not been left in proper order.

Our investigation found that a rub down body search was conducted at the same time as the cell search and Mr C was in the vicinity of his cell when it was being searched. He should therefore have been allowed to identify his legal documents. They should have been examined in his presence but not read and he should have been allowed to remove them before the cell search. A Judicial Review in 2003 determined that *'the prisoner should be confident that the confidentiality of the documents will not be compromised.'*[2]

The NIPS apologised to Mr C and accepted a recommendation to remind staff they must ensure the confidentiality of privileged documents when conducting a cell search.

[2] Neutral Citation No [2003] NIQB 23

Missing Property

Mr D was unhappy with how a property claim had been processed. The complaint related to the whereabouts of a gold chain that had gone missing three years earlier and who was responsible. The Prison Claims Unit made an offer of compensation but this was declined by Mr D. He then took his claim to the Small Claims Court but his claim was rejected as he had no proof of ownership.

The main element of Mr D's complaint to our office related to how the prison had investigated the loss and possible theft of the chain.

We made a number of recommendations including better facilities for safe storage of prisoners' property and reliable methods of recording property details to provide audit trials and accountability. The Governor confirmed that a secure tagging system had been introduced, with clear audit trails and indicated that security locks had been put in place in the main property store.

Visitor Complaint

Ms E complained when her visit was suspended without prior notice. Prison staff had reported that on her previous visit, she threatened a passive drugs dog and it's handler after the dog indicated on a member of her party. Her visit was allowed to proceed on that occasion but admittance was refused on arrival for her next visit.

The Prison Service deemed Ms E's behaviour 'unacceptable' but imposed no further sanctions. She accepted she had muttered in frustration at the time and commented that the dog *"should be put down."* We found that, while the comment was made, there was no suggestion that she was physically threatening or abusive to the dog or its handler. We concluded that suspension of the subsequent visit was an overreaction and recommended it should be re-instated. We also recommended she should receive an apology.

Although the Prison Service accepted the first recommendation they did not accept that an apology was appropriate, stating that it was reasonable to suspend the visit pending the outcome of their internal investigation. The visit was reinstated and Ms E welcomed the conclusions and recommendations made.

Access to Library

Mr F complained about not being able to borrow books from the library. The Prison Service advised him that the library IT system had developed a malfunction and services had to be temporarily suspended while technicians tried to fix the problem. Mr F was not happy with that response, maintaining that he was *"being wrongfully denied my right to borrow books at least once per week as provided in NI Prison Rules."*

We asked library staff if consideration was given to manually issuing books while the system was down. They said this was not feasible as around 150 prisoners passed through the library daily and each could borrow up to six books. The Prison Rules state that *"a library shall be provided in every prison and every prisoner shall be allowed to have books or other items borrowed from the library, and to exchange them, under such conditions as the Governor may determine."* However as there is no requirement in the Rules to provide the service on a weekly basis, this complaint was not upheld.

Detention in the Care and Supervision Unit

A number of prisoners complained about being asked to move from the CSU into the general population where they believed there would be a risk to their safety. Although the NIPS did not have any information to suggest there was any such risk, the prisoners still refused to leave the CSU. The NIPS advised the prisoners that it was their intention to move them to a residential location and that if they refused they would be charged and placed on Rule 35(4) (which empowers NIPS to keep charged prisoners apart from other prisoners pending adjudication). However, they also explained that the prisoners would not be moved from the CSU by force.

The Ombudsman recognised the difficulties for anyone living in the CSU environment for a prolonged period of time, but found that the NIPS were acting legitimately within Prison Rules. Although we did not uphold the complaint, we recommended that special effort should be made to mitigate the impact of isolation for prisoners who spend lengthy periods in the CSU, including proportionate charging and adjudication decisions, and maximising opportunities for association with other prisoners. The NIPS accepted this recommendation and advised that a new regime was introduced for all occupants of the CSU in November 2014. They added that although prisoners who refuse to leave the unit are normally charged, this was not the case for the prisoners who raised these complaints.

Use of Restraints during Hospital Visits

A prisoner complained about being humiliated by being handcuffed during a medical examination at an outside hospital. The Prison Service maintained that this was necessary because the individual was a Category A prisoner.

The Security Manual clearly stated it was appropriate for a Category A prisoner to be handcuffed during transit to hospital. However, the manual was ambiguous regarding the use of handcuffs while in the treatment room. It appeared to suggest that handcuffs can be removed, providing the room was secure and the officer in charge conducted a risk assessment and considered it safe to do so. Although a risk assessment was carried out, the NIPS said these assessments only deal with staffing levels required and not the use of restraints. However, the Security Manual states that the risk assessment *"…will decide the level of escort and restraint required for the safe custody of the prisoner".*

We recommended the NIPS should review the Security Manual to avoid ambiguity. The NIPS accepted the recommendation and advised that a review had been undertaken both at Establishment and Operational Management Board levels.

Late Unlocks

We received a large number of complaints about late unlocks at Maghaberry Prison. The Prisoner Ombudsman's Office has been increasingly concerned about the negative impact of late unlocks on prisoners, which is further compounded by unpredictable lockdowns. This is recognised by the Prison Service but they explained that they are experiencing unprecedented staffing shortages as a result of high levels of sickness absence and staff vacancies. We recommended that all possible opportunities are utilised to enable prisoners to maximise their time out of cell and we continue to actively monitor this situation.

Loss of Home Leave

A prisoner complained about the loss of his home leave for a period of three months following an adjudication. The charge related to having illicit medication in his cell. The prisoner explained that the medication had previously been prescribed to him but he was no longer taking it. He was found guilty by the adjudicating governor and given a caution.

The adjudication records showed that he pleaded guilty to the charge of possessing medication that was no longer being prescribed to him and he was awarded loss of home leave for a period of three months. As the prisoner was guilty of an offence against prison discipline we concluded that the award of loss of home leave, whilst unfortunate, was not unreasonable and did not uphold the complaint.

Deaths in Custody

The Prisoner Ombudsman initiated investigations into three deaths in custody, five post release deaths and two serious self-harm cases.

Two of the DiC investigations involved Maghaberry prisoners and one was in Magilligan. There were no deaths in Hydebank Wood or Ash House. The Magilligan death appeared to be self-inflicted and the causes of the Maghaberry deaths remain undetermined pending post-mortem results.

The deaths of five ex-prisoners shortly after release were also notified to us during the year. Each was subject to a preliminary investigation to establish whether there was any link to their time in custody. To date post-mortem results and toxicology tests in four of these investigations have not shown any such link. Rather in each of these deaths it was apparent that 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. The fifth investigation of this type centres on the care provided to a prisoner who was diagnosed as terminally-ill prior to his release.

We completed seven investigations between 1st April 2014 – 31st March 2015; and five reports were published during the same period.

On 31st March 2015 we had four DiC investigations, six post-release investigations and two serious self-harm investigations ongoing.

During the year we heard of several situations where prisoners almost died in each of Northern Ireland's prisons, but were saved by prompt intervention by NIPS and SEHSCT staff. Abuse of "legal highs" and/or prescribed medications featured in many of these situations. The trend of prisoners abusing illicit substances appears to be increasing and is a major concern since it poses very serious risk to life.

We made 78 recommendations for improvement in the reports that were completed and published this year, all of which were accepted by the NIPS and the SEHSCT. The main recommendations involved communication, the process for Supporting Prisoners at Risk (SPAR), anti-bullying procedures, staff support, recording practice, misuse of drugs, medication policy and referral to support services.

Eighteen of these recommendations had previously been made, and accepted by the NIPS and the SEHSCT. This is a matter of concern as the need to repeat recommendations indicates failings at managerial and operational levels and possibly also systemic failings. There has been good practice by NIPS and SEHSCT staff and improvement in certain areas. However the progress is undermined by failure to implement recommendations that were accepted. Families of deceased prisoners are frustrated when they learn it is necessary to repeat such recommendations. It also regrettably leads them and other prisoners, to question the benefits of prison oversight.

Having previously raised this concern in individual cases, as well as at the Ministerial Forum for Safer Custody, I wrote to the Ministers of Justice and Health in November 2014. Both ministers responded to say they were concerned about the need to repeat recommendations and that the matter was being treated seriously by the NIPS and the SEHSCT.

Comparisons
Despite NIPS staff reductions, the situation in Northern Ireland prisons was not as alarming as in England and Wales where in 2013-14 there were 90 apparent self-inflicted deaths, a 64% increase on the previous year. Natural causes deaths increased by 7% and there were four homicides, compared to two in the previous year[3].

Some useful context and historical perspective is also provided in other official reports:

Safety in Custody Statistics England and Wales
The 2014 *Safety in Custody Statistics* pointed out that in 2013 the rate of self-inflicted deaths among the prison population was 89 per 100,000 people, compared to a rate amongst the general population of 11.6 per 100,000 people[4].

Prisoner Ombudsman for Northern Ireland Annual Report 2007-08
*"I have formed the view that the rate of deaths in custody within the NIPS is comparatively low. In particular the suicide rate is low, a remarkable fact given the poor mental health of many prisoners." (*Page 20)

Irish Inspector of Prisons Omnibus Report September 2014
There were 34 deaths of prisoners in the Republic of Ireland between January 2012-June 2014: 15 in prison and 19 while prisoners were on temporary release.

[3] http://www.ppo.gov.uk/wp-content/uploads/2014/09/PPO-Annual-Report-2013-14_FINAL_web.pdf
[4] Table 1.1, Ministry of Justice (2014) Safety in Custody Statistics Quarterly Update to March 2014 - Deaths in prison custody 1978 to 2013, London: Ministry of Justice and Office for National Statistics (2014) Suicides in the United Kingdom, 2012 Registrations, Newport: Office for National Statistics

External Communication

The Prisoner Ombudsman maintained a wide range of external communication during 2014-15.

The publication of each DiC report and the 2013-14 Annual Report were accompanied by a press release and where appropriate, supplementary communications activity.

The Prisoner Ombudsman maintained contact with relevant bodies during the year. These included the Coroner's Service, the Parole Commissioners, Independent Monitoring Boards, 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, Prison Officers Association, British-Irish Intergovernmental Secretariat, Prison Review Team Oversight Group members and HM Inspectorate of Prisons.

He participated in the Ministerial Forum on Safer Custody and met a visiting delegation from the New York City Bar Association. He met local political representatives, Oireachtas TDs and Senators, and assisted in judging the Justice in the Community Awards in September 2014. He met monthly with the NIPS Director General and held quarterly meetings with the governor of each prison.

The Prisoner Ombudsman 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 news sheet, was our main vehicle for communicating with all prisoners. It includes case studies, statistics and information about the complaints process in eight languages. Inside Issues was published in July and December 2014.

Finance

The DOJ Internal Audit Unit Finance & Governance Audit 2014-15 provided a "Satisfactory" level of assurance.

The Prisoner Ombudsman's budget for 2014-15 was £574,000. 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 between the DOJ and the office. It places particular emphasis on:

- The Prisoner Ombudsman's overall aims, objectives and targets in support of the DOJ's wider strategic aims, outcomes and targets contained in its current Public Service Agreement;
- 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 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 31st March 2015, 100% 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 was "Satisfactory." It made one Priority 2 recommendation for improvement which related to delay in re-tendering a contract, a matter that was beyond our control.

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. The Information Security Policy was revised and reissued to staff in June 2014 and a range of other dynamic and static control measures are in place.

We had requested an advisory visit by the Information Commissioners Office (ICO) in January 2014 and this took place in September 2014.

The ICO also reviewed an aspect of our work in May 2014. The ICO concluded regulatory action was not required and recommended that all relevant staff members should be made aware of their obligations under the Data Protection Act; and that appropriate technical and organisational measures should be in place to prevent unauthorised processing of personal data. Action has been taken to implement these recommendations.

Risk Management and Internal Control

A number of risks were re-evaluated during the year and the Risk Register was updated in September 2014 to reflect the highest 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 Financial Services Division.

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

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

The
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