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Foreword

I am pleased to present my first Annual Report as Prisoner Ombudsman, which covers the period April 2018-March 2019.

I took up office on 1st March and am pleased to publish this Annual Report which represents work done under the oversight of Brendan McGuigan, Chief Inspector, Criminal Justice Inspection Northern Ireland. I want to put my thanks to Mr McGuigan on record given the additional responsibilities he so willingly accepted and the professionalism with which he carried out his responsibilities.

At present, the Prisoner Ombudsman’s work is entirely demand-led. My office responds to complaints as they are raised, regardless of the volume. In year we have experienced a significant increase in the volume of complaints by 74%. The office investigates deaths in custody and this year we commenced investigations into eight deaths, three at Magilligan prison and five at Maghaberry. Five of those deaths appear to be self-inflicted and the remainder natural causes. Additionally, investigations are carried out into post release deaths and incidents of serious self-harm as required and requested. This year, in addition to the eight death in custody investigations, the investigations team began investigations into two incidents of serious self-harm and two post release deaths. Volumes are unpredictable from year to year. During this reporting period the volume of work has clearly been significantly higher.

During the year, 6 death in custody investigations were completed and 5 were published. We made 35 recommendations for improvement in four of the reports. 31 of the recommendations have been accepted by the Prison Service and Trust (South Eastern Health and Social Care Trust).

It is critical that prisoner’s understand the importance of the complaints system and how it can contribute to improvement. It is equally important that prisoners have the confidence to bring forward their complaints and that prison officers understand their right to do so. Not all complaints are upheld but, where they are, the aim is to ensure the treatment of prisoners is as it should be. Without this mechanism, in harmony with other systems to ensure prisoners are treated well, the chances of success are limited. We will continue to work to increase the number of complaints coming from young men and female prisoners in particular.
We received 408 individual complaints, a significant 74% increase on last year when 234 individual complaints were received. More than half of these complaints came from integrated prisoners and the others were complaints from separated prisoners on Roe 3 and 4 landings at Maghaberry prison. A change of practice has been required in relation to the investigation of complaints from the separated regime in Roe House. In practice multiple complaints relating the same issue were treated together. In year a change has been made to address complaints individually. The office must remain agile and thoughtful in response to the number of complaints received in order to continue to deliver a quality, effective, independent service.

We made 140 recommendations for improvement in relation to prisoners’ complaints. At the time of writing 89% of these had been accepted by the Prison Service.

The process for placing this office on a statutory footing progressed through the Northern Ireland Assembly and the Justice (No 2) Bill received royal assent on 12th May 2016. It remains a disappointment that underpinning Regulations could not be completed before dissolution of the Assembly on 26th January 2017.

I am looking forward to working alongside staff to improve our service so that it is more responsive for prisoners and for families of those who lose loved ones in particular. I am grateful for the co-operation of the Prison Service and the Trust and for the shared vision of prisons as a place in which people can be given every opportunity to turn their lives around and receive the support, challenge and help that they need thus returning to society to contribute to a safer society for all.

However, concerns still remain about the timeliness of our work and about the contribution delay in getting material from the Prison Service and Trust has on that timeliness. I recognise there are challenges for those organisations but good investigations are timely and the role each of us play in timeliness is, therefore, important. In the case of deaths in custody, delay has a significant impact on the grieving process of those who lose ones and is, therefore, to be avoided at all costs.

Finally, I am grateful to everyone in the Prisoner Ombudsman’s Office for their contribution throughout the year and for the way in which they have welcomed me into post.

Lesley Carroll
Prisoner Ombudsman for Northern Ireland

September 2019
Background

The Prisoner Ombudsman’s Office was set up in 2005 following the Steele review which was commissioned because of concerns about staff and prisoner safety in Maghaberry Prison. Amongst other things, the review suggested that the 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:
- Investigate and report on Complaints from prisoners and their visitors; and
- 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 Prison Service to investigate deaths in prison. She does not have any statutory powers in this matter. In addition the Ombudsman investigates post-release deaths (occurring within 14 days of release from prison) and incidents of serious self-harm within prisons.

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. 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 Prison Service and SEHSCT, on the basis that we all share the common aim of improvement. Draft Death in Custody reports are shared with the Prison Service, 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 complainants and the Prison Service to ensure factual accuracy; and we ask the Prison Service 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

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 Prison Service 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 previous Prisoner Ombudsman, Tom McGonigle, retired from post on 31st August 2017. In the absence of a Justice Minister to appoint a successor, Brendan McGuigan (Chief Inspector, Criminal Justice Inspection Northern Ireland) was asked by the Department of Justice to oversee the Ombudsman’s Office in the interim. He carried this responsibility until Lesley Carroll was appointed Prisoner Ombudsman from 1st March 2019.

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 her 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 managerial roles by two Senior Investigators. The management team receives monthly 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. She meets regularly with the South Eastern Health and Social Care Trust in respect of death in custody investigations.

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 31st March 2019 the staff complement comprised the following:

- Prisoner Ombudsman
- Director of Operations
- 2 x Senior Investigators
- 6 x Investigators; and
- 3 x Administrative Support staff.

The Prisoner Ombudsman is a public appointee and all other staff are established civil servants.

The Prisoner Ombudsman's Office aims to conduct itself according to 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 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 2018-19 opening budget was £638,000, 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.

Corporate and Business Planning

A Business Plan for 2018-19 was published in June 2018, setting out more precisely the annual objectives and resources to be employed to achieve them. A Corporate Plan will be produced by October 2019 to set out the vision for the office and the work that flows from that vision.
Management Commentary

Statistical Headlines for 2018-19

- Investigations initiated into the deaths of 8 prisoners, 2 ex-prisoners and 2 incidents of serious self-harm
- 6 investigations completed by the DiC team and 5 reports published
- 35 recommendations for improvement made in DiC and post-release reports of which 32 (89%) were accepted
- 408 individual complaints received, an increase of 74% from 2017-18
- 83% of integrated prisoners’ complaints came from Maghaberry
- 34% of complaints were Upheld or Partially Upheld
- 140 recommendations for improvement were made in complaints reports of which 89% were accepted at time of writing

Performance against targets 2018-19

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

1. Statutory Footing

Subject to legislation being in place, identify issues to be addressed in the underpinning Regulations; and update Terms of Reference for investigating deaths in custody and complaints;

Contribute to the Department of Justice Statutory Footing Working Group;

Address staffing implications for current PO staff;

Deliver all aspects of the new offices remit as provided by statutory footing, including name change, rebranding and new website;

Communicate to stakeholders and promote the new Office of Prison Ombudsman for Northern Ireland.

The Justice [No.2] Bill received royal assent on 12th May 2016. Work on the Regulations commenced in June 2016 and continued through to the early part of 2017-18 when it was suspended pending the return of the NI Assembly and the formation of a Justice Committee.
2. Complaints and DiC Investigations

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.

The “Lessons Learned” process to evaluate all DiC investigations and reports, as well as significant complaint investigations and reports, continued to provide a useful quality control mechanism.

Ensure full compliance with Complaints and Death in Custody Terms of Reference by Investigators.

Internal review of all DiC reports and complaint reports 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 maintain standards and support their professional development.

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

Not achieved – Delivering investigations in line with the performance target to issue draft reports within 9 months remains challenging for a variety of reasons including: the ability to complete interviews; receive timely responses to requests for information; delays at the factual accuracy stage; and staffing within the Office of the Prisoner Ombudsman.

85% of all complaints cleared were finalised within the 18 week target. The main reasons for failing to reach this target include: delays in receiving material; accessing witnesses for interviews and receiving feedback from the Prison Service.

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

Achieved.

Conduct a quarterly validation exercise within each prison of accepted recommendations in complaints reports.

Achieved – A quarterly validation of accepted recommendations was undertaken with the full cooperation of the Prison Service.
In response to the low number of complaints received from each establishment, we will conduct dip sample exercises in Magilligan Prison and Hydebank Wood College of complaints that were finalized at internal Prison Service Stages 1 & 2.

_Achieved – Dip sample exercises were completed as planned at both Hydebank Wood and Magilligan._

Assess implementation of accepted Death in Custody 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.

_Not Achieved – Due to pressure of other work._

Maximise accessibility for everyone who has contact with our services. Ensure low user groups – such as female prisoners, young offenders, foreign national prisoners and visitors - have opportunities to understand the role of the Prisoner Ombudsman.

_We continued to address underuse of our service by certain groups. Efforts included introducing monthly “clinics” at Hydebank Wood for young male and female prisoners. The numbers of formal complaints from low users did not increase but we identified several local concerns and ensured prison managers were made aware of them. We also introduced monthly complaints “clinics” at Magilligan Prison and although the number of complaints received from here has increased, the numbers remain low._

“Inside Issues” was prepared and circulated to every prisoner in July 2018 and January 2019.

3. _Support for Prison Service Complaints Handling_

_Assist the Prison Service to improve local resolution of complaints._

_Efforts continue to encourage informal local resolution through the provision of telephone advice to prisoners and taking forward issues raised at the “clinics”. _

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

_No requests received._

4. _Support for the Prison Service & SEHSCT Partnership Working_

_Meet monthly with the Director of the Reducing Offending Division, and quarterly with prison governors to share feedback from investigations and matters of mutual interest._
Formal meetings with the Prison Service Director General and prison governors were conducted throughout the year to discuss DiC and Complaint findings, address areas of concern and recognise progress.

Meet regularly with South Eastern Health & Social Care Trust (SEHSCT) senior managers to share feedback from DiC investigations and other matters of mutual interest.

Formal meetings with the SEHSCT Director & Assistant Director of Prison Healthcare took place on a six-monthly basis throughout the year.

Meet regularly with other stakeholders including CJI, Independent Monitoring Boards, the Coroner, RQIA, ICRC and the Northern Ireland Public Services Ombudsman to share feedback from investigations and other matters of mutual interest.

The Prisoner Ombudsman and Director of Operations met these bodies regularly, and also with others such as the International Committee for the Red Cross and international visitors.

Contribute to the training of the Prison Service and SEHSCT staff if requested.

The Director of Operations contributed to several training events for Prison Service new recruits.

5. Corporate Affairs

Prepare a 2018-2021 Corporate Business Plan (Subject to the appointment of a Prisoner Ombudsman)

Production of a three year Corporate Plan was placed on hold awaiting the appointment of a Prisoner Ombudsman.

Monitor our financial performance against the budget allocation for 2018/19 of £638k (90% staff costs and 10% non-staff costs) and strive to work within the required budget variances of 1% with no overspend;

Achieved.

Publish annual report by September 2019.


Issue two editions of ‘Inside Issues’ magazine to prisoners.

Complaints

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 Prison Service 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.

On 1st April 2019 there were 1,444 people in the three prisons in Northern Ireland. Prison Service data for April 2018 – March 2019 shows:

5,338 complaints were made to the Prison Service, of which:
- 3,839 (72%) were closed at Stage 1
- 1,003 (19%) were closed at Stage 2
- 476 (9%) were closed as rejected or upon the prisoner’s release
- 20 (<1%) were still open on 31st March 2019

Separated Republican prisoners on Maghaberry Roe 3 and 4 landings lodged 437 complaints, a significant decrease of 84% on last year. The number of complaints made to the Prison Service by other prisoners (4,901) reduced - by 3% - from last year (5,070). This reduction was commensurate with a lower prison population. It may also be partially explained by a more stable regime in Maghaberry; and by improvement in complaints-handling there during the reporting period.

There are various reasons for complaints being closed. These vary from prisoners receiving a reasonable answer, through to being discharged from custody (at which point the Prison Service closes a live complaint as it feels unable to offer an effective remedy), 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 Prison Service business; and it can indicate to prisoners that they are not being treated seriously.

Complaints only become eligible for investigation by the Prisoner Ombudsman’s Office after Prison Service 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 developing into complaints; and many prisoners instruct law firms in Judicial Reviews. During 2018-19 we continued our outreach efforts to ensure low user groups, such as foreign national prisoners, females and young men, were aware of our office and knew how to complain properly.
Table 1 – Individual Complaints Received by Prisoner Ombudsman 2018/19

<table>
<thead>
<tr>
<th>Location</th>
<th>Individual Complaints 2018/19</th>
<th>Percentage of all complaints</th>
<th>Percentage of complaints</th>
<th>Percentage of overall prison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roe 3 &amp; 4*</td>
<td>149</td>
<td>37%</td>
<td></td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Maghaberry Others</td>
<td>216</td>
<td>53%</td>
<td>83%</td>
<td>57%</td>
</tr>
<tr>
<td>Magilligan</td>
<td>36</td>
<td>9%</td>
<td>14%</td>
<td>32%</td>
</tr>
<tr>
<td>Hydebank Male</td>
<td>1</td>
<td>-</td>
<td>&lt;1%</td>
<td>6%</td>
</tr>
<tr>
<td>Ash House</td>
<td>6</td>
<td>1%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Overall Total</td>
<td>408</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*A further 205 multiple complaints were received from these locations*

**Integrated Prisoners**

259 complaints were escalated to our office by integrated prisoners, an increase from 167 in 2017-18. This represents only 5% of all the complaints that prisoners initiated via the Prison Service Internal Complaints Process.

Table 1 illustrates that 83% (216/259) of integrated prisoners’ complaints to our office came from Maghaberry Prison. Like young men in custody throughout the UK, those in Hydebank Wood make little or no use of the official complaints system; and complaint rates from the women prisoners in Ash House have always been very low. Magilligan's overall total has increased from last year but remains low.

We conducted dip samples of complaints that were closed by the Prison Service at Stages 1 & 2 of their Internal Complaints Process at Hydebank Wood/Ash House and Magilligan during 2018/19, in order to assess whether those complaints had been dealt with fairly and an adequate response provided to the complainant. 86% of Magilligan complaints, 74% of male complaints and 63% of female complaints were deemed to have been dealt with appropriately, with evidence of a proper investigation and adequate stage 1/stage 2 response. However in both instances there was evidence of significant flaws within the internal complaints process with a total of fifteen recommendations for improvement made.

**Roe 3 & 4**

Separated Republican prisoners held on Roe 3 and 4 landings at Maghaberry Prison lodged 149 individual complaints in 2018/19, compared to 67 in the previous year. By contrast the number of multiple complaints received fell from 1719 to 205 over the same period. During 2018-19 they comprised less than 1% of the total prison population, but made 37% of the complaints that were received by our office.
Table 2 – Complaints cleared April 2013 – March 2019

<table>
<thead>
<tr>
<th>Year</th>
<th>Investigated &amp; Reported</th>
<th>Local Resolution</th>
<th>Withdrawn/Released</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018-19</td>
<td>275 (82%)</td>
<td>2 (&lt;1%)</td>
<td>60 (18%)</td>
<td>337</td>
</tr>
<tr>
<td>2017-18</td>
<td>252 (81%)</td>
<td>13 (4%)</td>
<td>47 (15%)</td>
<td>312</td>
</tr>
<tr>
<td>2016-17</td>
<td>220 (72%)</td>
<td>4 (1%)</td>
<td>84 (27%)</td>
<td>308</td>
</tr>
<tr>
<td>2015-16</td>
<td>1419 (92%)</td>
<td>31 (2%)</td>
<td>65 (6%)</td>
<td>1,515</td>
</tr>
<tr>
<td>2014-15</td>
<td>873 (82%)</td>
<td>143 (13%)</td>
<td>52 (5%)</td>
<td>1,068</td>
</tr>
<tr>
<td>2013-14</td>
<td>378 (81%)</td>
<td>58 (12%)</td>
<td>32 (7%)</td>
<td>468</td>
</tr>
</tbody>
</table>

A total of 312 complaints were cleared by this office during 2018-19 (Table 2).

Table 3 provides a breakdown of outcomes for the complaints that were investigated and reported on by this office.

Table 3 – Outcomes for Complaints Investigated April 2013 – March 2019

<table>
<thead>
<tr>
<th>Year</th>
<th>Upheld</th>
<th>Partially Upheld</th>
<th>Not Upheld</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018-19</td>
<td>49 (18%)</td>
<td>45 (16%)</td>
<td>181 (66%)</td>
<td>275</td>
</tr>
<tr>
<td>2017-18</td>
<td>46 (18%)</td>
<td>108 (43%)</td>
<td>98 (39%)</td>
<td>252</td>
</tr>
<tr>
<td>2016-17</td>
<td>39 (18%)</td>
<td>45 (20%)</td>
<td>136 (62%)</td>
<td>220</td>
</tr>
<tr>
<td>2015-16</td>
<td>616 (43%)</td>
<td>146 (10%)</td>
<td>657 (46%)</td>
<td>1419</td>
</tr>
<tr>
<td>2014-15</td>
<td>473 (54%)</td>
<td>173 (20%)</td>
<td>227 (26%)</td>
<td>873</td>
</tr>
<tr>
<td>2013-14</td>
<td>216 (57%)</td>
<td>26 (7%)</td>
<td>136 (36%)</td>
<td>378</td>
</tr>
</tbody>
</table>

Most of the complaints that we upheld were of a procedural nature and there were few serious allegations. However the significance for complainants should not be underestimated: lengthy lockups, delayed mail and minor damage to personal possessions can have a seriously destabilising effect on prisoners who have limited opportunities for contact with their families and few personal possessions.

We made a total of 140 recommendations for improvement in response to prisoners’ complaints during 2018/19. At the time of writing 89% of these had been accepted, 10% rejected, and 1% were awaiting a decision from the Prison Service.
Table 4 – Maghaberry Integrated Prisoners Main Complaint Topics 2013-19

<table>
<thead>
<tr>
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<td>Staff attitude</td>
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<td>51</td>
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<td>32</td>
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<td>6</td>
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<td>15</td>
</tr>
<tr>
<td>Tuckshop</td>
<td>11</td>
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<td>-</td>
<td>-</td>
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<tr>
<td>Complaint Procedure</td>
<td>9</td>
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<tr>
<td>Mail</td>
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<td>7</td>
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<td>Discrimination</td>
<td>8</td>
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<td>Visits</td>
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<td>Transfers/Allocation</td>
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<td>6</td>
<td>7</td>
<td>9</td>
<td>12</td>
<td>19</td>
</tr>
<tr>
<td>Regime</td>
<td>6</td>
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<td>7</td>
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Prioritisation of Complaints

Complaints to this office are typically dealt with in the date order they are received. However in June 2017 we introduced a formal process whereby in exceptional circumstances complaints received could be prioritised. This is communicated to all complainants when they receive a letter from us to indicate that a particular complaint has been deemed eligible. Complainants are also advised of the criteria that we use in determining prioritisation and how to make such a request. In 2018-19 we received 31 requests for prioritisation, 29 of which were accepted.
Mr. A complained that Prison Service staff took and destroyed his training shoe.

The Prisoner Ombudsman’s investigator established that the Prison Service had destroyed the shoe. The Prison Service provided an explanation that they were unable to verify who owned the shoe.

This explanation was considered questionable by the Prisoner Ombudsman’s office as:
1. Prison Service staff were aware Mr. A was returned to his cell without a shoe, having been alerted by CCTV operators that Mr. A had removed his shoe.
2. Mr. A had raised a request 3 days later to have his remaining shoe destroyed so he could obtain a new pair.

On this occasion, the Prison Service also failed to secure CCTV that was requested.

Mr. A’s complaint was upheld. The Prisoner Ombudsman made the following recommendations that were accepted:
- Mr. A receives compensation for the cost of his shoes.
- The Prison Service do not destroy prisoners’ property without making proportionate efforts to identify the owner.
- The Prison Service ensure CCTV requests from the Prisoner Ombudsman’s Office are actioned promptly.

Mr. B complained about the Prison Service refusal to buy headphones which he requested for a large part of his Open University Course. The Prison Service considered the financial support provided by the Distance Learning Policy did not apply to the headphones.

The Prisoner Ombudsman investigator confirmed that no headphones were available and obtained the view of the teaching staff that headphones would be beneficial for any pupil using audio material to learn and also for other pupils in that the disruption to their learning would be less.

Considering that the headphones were requested to listen to audio material when in the classroom and could be deemed tutorial support, the Prisoner Ombudsman believed the request should have been approved.
Mr. B’s complaint was upheld. The Prisoner Ombudsman made the following recommendations that were accepted:

- The Prison Service support requests for tutorial support, when it is evident that the request is directly related to assisting the prisoner with their studies.
- The Prison Service provide the Learning and Skills Department with headphones to enable prisoners to listen to audio material without causing disruption to others in the classroom.

Mr. C complained that he received his daily newspapers a day late on three separate occasions. He requested compensation for the full amount which was £3.00 and was told that no claim form would be issued in this regard as he was not “adversed financially”.

The Prisoner Ombudsman investigator established that the newspapers were delivered from a local shop and investigated the process for having them logged through the Prison Service system before they were delivered.

The Prisoner Ombudsman partially upheld the complaint as the newspapers were received albeit a day late and made the following recommendation which was rejected by the Prison Service:

- That the Prison Service prioritise the processing of newspapers to ensure that prisoners who use and pay for the service receive their daily papers on the day they are delivered by the shop.

The Prison Service said that they were unable to accept the recommendation made as the Senior Management Team of the prison currently endeavour to ensure that all facilities are maintained. They also said that all prisoners have access to television (all with red button access) and radios so there is no impediment to keeping up with current affairs.

Ms. D was permitted to buy perfume. She did not state the purpose of her purchase. Ms. D complained that when she later requested the perfume be left in Visitors’ Reception for her daughter to collect, she was refused. Ms. D explained the purchase was a birthday gift for her daughter and collection by her daughter had been previously permitted. She believes it is important for prisoners to maintain family contact and maintain a meaningful role.

The investigation established that there had been previous requests approved which permitted the purchase of gifts using the Local Purchase Facility, which were then permitted to be collected by family. However, the investigation also established the new facility was introduced to permit the purchase of gifts for children and grandchildren under the age of 18.
Although the policy does not extend to the purchase of gifts for adults, the Prisoner Ombudsman’s Office welcomes its introduction and acknowledges the Prison Service rationale for the limitations built into the policy.

The Prison Service were, however, unable to provide written guidance on applying the Local Purchase Facility.

The complaint was partially upheld and the Prison Service accepted recommendations to:
- Permit Ms. D to pass the gift out to her daughter, as a good-will gesture in recognition that previous similar requests had been allowed without issue.
- Issue guidance on the Local Purchase Facility to ensure prisoners are fully aware of the restrictions in place.

Ms. E made a complaint about being subjected to sectarian abuse when in the exercise yard and about the privacy and security of the yard. The Prisoner Ombudsman’s investigation established that a work party entered a normally restricted area unannounced, leaving Ms. E feeling intimidated and unable to remain in the yard.

The investigation established that the other prisoners were allowed supervised access to the yard to carry out maintenance. However access was not through the proper entrance and no-one was informed they would be in attendance. The investigation also established that in response to receiving the complaint the Prison Service: promptly placed the abusive prisoner on report; had completed remedial work to improve the privacy of the yard; planned to complete further improvement work. In addition, the Prison Service locked the entrance that should not have been used and assured future work would be coordinated to prevent work being completed when the yard was in use.

Less positive, although it may not have changed any investigative conclusions, is that the Prison Service did not provide CCTV footage when requested.

The complaint was upheld.

While the Prison Service are upgrading their CCTV to improve the area it covers, they have accepted the recommendation to ensure that CCTV footage is retained and provided to interested parties irrespective of the orientation of the camera or its view.

Following an investigation under the Anti-Bullying Policy, Mr. F had requested that he would not be placed in the same location as another prisoner who was subject to that investigation. However, the other prisoner was then placed in work in the same work location.
Mr. F was never informed of this beforehand and complained that the other prisoner continued to harass and intimidate him in his work place. He explained that despite the Anti-Bullying investigation his concerns were not considered, the least he would have expected was for the Prison Service to have spoken to him about his concerns and allow him to prepare to work with the other prisoner.

A Governor acknowledged that Mr. F should have been made aware the other prisoner would be working in the same place as him. The Governor stated it had been his intention to address the issues between both prisoners using restorative measures in a controlled environment, rather than them meeting by chance. The Governor apologised and gave Mr. F an assurance that there were a range of actions designed to safeguard him from bullying.

The Prisoner Ombudsman’s Office also found no evidence to suggest that the Prison Service had investigated the continued harassment and intimidation reported by Mr. F.

The Ombudsman’s Office partially upheld the complaint. The Prison Service accepted recommendations to:
- Ensure that all allegations of bullying are investigated and documented in accordance with the Anti-Bullying Policy.
- Ensure that when a prisoner who has been found guilty of bullying is being placed in a location where the victim is present, that the victim is informed beforehand and sufficient preparatory work is undertaken to ensure that the integration is managed closely.
- Issue Mr. F with a formal written apology for the distress caused by not being informed of the other prisoner being placed in the same location.
Deaths in Custody

We initiated investigations into eight deaths in custody, two post-release deaths and two incidents of serious self-harm.

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.

During the reporting period we commenced investigations into eight deaths in custody. Five involved prisoners at Maghaberry and three involved Magilligan prisoners. There were no deaths at Hydebank Wood or Ash House. Five deaths appeared to be self-inflicted and the other three appeared to be from natural causes. Definite causes of death in all cases are only determined at the Coroner’s inquest.

In addition there were two post-release death investigations initiated. Each post-release death was subject to a preliminary investigation to establish whether there was any link to the person’s time in custody. Investigations into two incidents of serious self-harm were also initiated during 2018/19.

In 2018/19 we completed six investigations, three deaths in custody and three post-release, and published five reports (four deaths in custody and one post-release).

The published reports contained 35 recommendations for improvement (20 for the Prison Service, 13 for the SEHSCT and 2 joint). Thirty-two of our recommendations were accepted.

On 31st March 2019 there were eighteen ongoing investigations – twelve death in custody, four post-release and two incidents of serious self-harm.

Comparisons

The Ministry of Justice’s “Safety in Custody Statistics Bulletin to March 2019” states that there were 317 deaths in prison custody in England and Wales in the twelve months to March 2019, an increase of 6% from 299 in the previous year. Three of these were apparent homicides, down from 5 in the previous year. There were 87 self-inflicted deaths, up 19% from 73 in the previous year.

Figures from the Scottish Prison Service indicate that there were 32 deaths in prison custody in 2018, three more than in 2017. In the Republic of Ireland figures from the Annual Report of the Office of the Inspector of Prisons for 2015 and 2016 show there 15 deaths in custody in 2015 and 5 in 2016.
Corporate Affairs

External Communication

Publication of one of the DiC reports published this year and the 2017-18 Annual Report were accompanied by a press release and where appropriate, supplementary communications activity.

Contact was maintained with relevant bodies during the year. These included the Coroner’s Service, the Regulation & Quality Improvement Authority, Criminal Justice Inspectorate and International Committee of the Red Cross.

The Ombudsman’s office held a monthly stock take with the Prison Service Director-General and a quarterly stock take with the governor of each prison was also held.

The interim Prisoner Ombudsman and Director of Operations were regular visitors to the prisons, where they met prisoners individually and collectively. They also met with prisoners’ families.

“Inside Issues,” a four page news sheet, was the Office’s main vehicle for communicating with prisoners. It included case studies, statistics and information about the complaints process in eight languages. Summer and Winter 2018/2019 editions were published and a copy was distributed for each person in the Prison Service custody at the time.

Finance

The Prisoner Ombudsman’s opening budget for 2018-19 was £638,000. 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 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 2019, 97% were paid within the 10-day timeframe.

The Annual Finance and Governance Report for 2018-19 by the DoJ Internal Audit Unit found the Prisoner Ombudsman’s showed an overall audit opinion of “satisfactory” and made two priority 3 recommendations.

In September 2015 the DoJ sponsor branch had proposed that their quarterly overview meetings with the Prisoner Ombudsman’s Office be reduced in frequency to a biannual basis, as they were content with levels of assurance in place. This process was maintained throughout 2018-19.

All proposed business changes were 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 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. A civil action which involved a data incident was settled during the year without admission of liability. Staff are trained in, and required to comply with, all NICS security policies and guidance.
Risk Management and Internal Control

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 HR Connect 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.