



# ***ANNUAL REPORT***

## ***2021-22***



The  
Prisoner  
Ombudsman  
for Northern Ireland



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## Foreword

It has been a privilege to continue to serve as Prisoner Ombudsman for NI and I am pleased to present the Annual Report for 2021-22. The year was as full of challenges as ever and I was pleased that the Minister extended my appointment to February 2024. Given the impact Covid-19 has had on delivery and working practice it is important to me that I can continue to build the work of the Office to properly and professionally complete investigations and bring the needs of those in custody to wider attention. Inevitably, my Office deals with worries and concerns and it is critical that we address those in a way that supports the Prison Service and the South Eastern Health and Social Care Trust (the Trust) to maintain standards and assure families that those in custody are treated decently and with respect.



This year we began to see some normality return to our work and recovery planning came into its own. Step by step we have begun to return to a working practice that allows more face to face engagement and presence within our prisons. This is helpful to staff and should increase confidence those in custody have in our work. Like others, we saw some of the 'fall-out' from Covid-19 perhaps most significantly in the wellbeing of those communicating with staff in the Office and with me.

The challenges faced by the Prison Service and the Trust during the Covid-19 pandemic were evident and the challenge of recovery is as significant as we all gather learning from different working approaches and apply them so that we can provide more efficient and effective ways of working. It was remarkable that there were no deaths due to Covid-19 in our prisons and I commend the Prison Service and Trust for their efforts in this respect. Nevertheless, I would expect to see impacts continuing for some time – Prison Officers and Healthcare in Prison staff will be aware more than anyone else of some of those impacts in terms of behaviours and the general wellbeing of those in custody. As across society, services feel the pressure of demand and staff experience the moral injury of not being able to meet the needs of those in their care in the way they might wish to.



Staff have become more accustomed to remote working and one of the significant challenges is to re-establish office-based working. In the year 2021-2022 the focus was more on essential cover as the year began and as the year progressed the challenge has increased as we move towards the kind of office based working that allows real engagement between staff. Collaborative working is essential in a business that addresses conflict and distress. In my view this will be one of the most significant and difficult operational challenges in the year ahead but it is essential that staff return to working together informally as is developed in the Office setting. At the same time, there have been real benefits to home working so the hybrid model will remain in place. I was glad that in July 2021 we were able to increase Freephone service provision to normal, pre-pandemic hours as this is a foundational service allowing those in custody, their visitors, family members and those recently released to raise matters of concern to my attention.

Last year I reported that towards the end of the year staffing, although more settled, was likely to remain challenging and this has proved true for much of this year. In particular, long-term vacancies and sickness continue to be the biggest hurdles faced. This is particularly true in a small Office in which staff depend on one another and the upshot has been an increased sense of vulnerability among staff as well as an impact on the timely delivery of investigations. Additionally, we had to defer crucial, strategic pieces of work planned for the reporting year, the most significant of those being preparations for Statutory Footing. Our focus remains almost exclusively on operations as we continuously seek ways to deliver our business and improve what we do with limited resources. We remain an Office that holds a vision of mustering the information we have to provide a persuasive evidence base for more speedy improvement.

Strategically, we have been successful in our decision to build stronger partner relationships, particularly with the Independent Monitoring Board, RQIA and CJINI. Following events in 2016 when the Office carried out investigations into a serious adverse incident and a number of suicides in prison, a review was commissioned by the Departments of Health and Justice to consider provision for vulnerable persons in custody. I have further emphasised this review in subsequent investigations which revealed that healthcare needs and collaborative working between the Prison Service and the Trust remain key issues of concern. I also wrote to the Prison Service Director of Reducing Offending, and asked him to raise this concern with both Departments. RQIA's long awaited report, *Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons*, was published on 05 October 2021 and set out a series of recommendations that have the potential to effect real change and improvement. The aim is to deliver recommendations within 18 months of publication of the report. I am keeping a watching brief on progress with the implementation of these recommendations as the work undertaken will continue to be crucial in ensuring that vulnerable individuals in custody are in receipt of timely and appropriate levels of care.



Every year brings disappointments, which are a reality of life. One of my greatest disappointments has been our inability to decrease the backlog of complaints. A number of different mechanisms were tested and staff have applied themselves. The Exceptional Assessment and Investigation Process (EAIP) continued to operate as the main mechanism to reduce the number of complaints awaiting investigation to 30 by the end of 2021. Although we were unable to meet this commitment, learning from the Exceptional Process has been important and as the year draws to a close I am convinced that the learning now needs to be applied into normal working practice and I anticipate a move back to normal business in the year ahead.

Within the Death in Custody team, temporary promotion arrangements continued to fill the Senior Investigation Officer (SIO) post. In 2020 an additional staff member had been added to the team but they have not been able to experience the benefit of that because of the ongoing temporary promotion arrangements. A recruitment exercise to fill the SIO post substantively took place in March 2022 and identified a suitable candidate. This candidate will take up post in July 2022. Those staff who took up the temporary promotion opportunity provided necessary leadership and support during a very challenging and trying period and I am particularly grateful to them for the way in which they worked with me to deliver a significant amount of work. Work to update the Terms of References for both Complaints and Deaths In Custody also requires review and this is planned for the incoming year.

In seeking to address the overall staffing shortfall, a temporary Grade 7 Director of Operations, Ann McCandless, was appointed in June 2021 after the post had been unfilled for a period of almost 6 months. During the time the post was vacant I found myself much more involved in the operational side of the office than would be normally expected from an Ombudsman. It has been a valuable experience and has given me greater insight into the stresses on staff and the process improvements that are required to provide a more robust and responsive service. Having said that I was delighted to have Ann added to the team and I want to express my gratitude to her for the way in which she quickly got up to speed and the considerable work she has been doing to support the wider team and focus their delivery on strategic objectives. It is regrettable but unavoidable at this point in time that it has not been possible to formalise arrangements or to appoint a permanent member of staff. I hold on to the ambition of resolving this matter in 2022/23.

More detail about both Complaints and Death in Custody operations is included in the body of my Report but I want to express my gratitude to those staff across the office who willingly stepped into unaccustomed roles.



I remain firmly of the view that effective digitisation will greatly assist in addressing backlogs and the shortcomings of existing processes, as will increased staff training and understanding of Ombudsman processes and the delivery of Statutory Footing. Statutory Footing in particular will be a focus for me in the year ahead and I will be working with staff to ready the Office for what is ahead.

Finally, I want to thank staff for their commitment and flexibility. I also want to thank the Minister for her support and Sponsor Branch staff whose ongoing support has continued to be invaluable. I am especially grateful to the Prison Service and Trust for their co-operative approach and assurance that we share the same vision for delivery of services that are professional and person centred. Without their co-operation the work of my Office would not be effective. At times we vehemently disagree but the collaborative, learning values that we share provide us a mechanism for working through our opposing views, to properly hear one another and to work towards improvement.

**LESLEY CARROLL**

**Prisoner Ombudsman for Northern Ireland**

**April 2023**

## Background

The Prisoner Ombudsman's Office was established in 2005 following the Steele review, which was commissioned because of concerns about staff and the safety of individuals in custody 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 current or former individuals in custody and their visitors; and
- ▶ Investigate and report on Deaths in Custody.

The Prisoner Ombudsman's powers regarding investigation of complaints by those in custody 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 Custody but does not have any statutory powers in this matter. In addition, the Ombudsman may investigate some post-release deaths (occurring within 14 days of an individual's release from prison) and serious adverse incidents occurring within prisons.

All 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, found on the website [www.prisonerombudsmanni.org.uk](http://www.prisonerombudsmanni.org.uk) govern the investigations carried out.

Detailed manuals are available to guide staff in the course of their investigations. These are updated as necessary.



One of the most productive way to promote improvement is by working in collaboration with the Prison Service and the Trust on the basis that we all share the common aim of delivering improvement. Draft Death in Custody reports are shared with the Prison Service, the Trust and the next of kin for comment and final reports are sent to the Minister of Justice and the Coroners' 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 redact dates or other identifying information before a report is published.

Draft complaint reports are shared with complainants and the Prison Service to ensure factual accuracy and we also 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 normally included in Annual Reports and in "Inside Issues" which is our bi-annual publication for people in custody to keep them informed about the work of the office and increase their knowledge of the complaints process and its value to them. It is disappointing that the Inside Issues magazine has not been published for the last couple of years mainly due to the impact of Covid-19 on business activities and a lack of available staff resources to undertake the work required to bring the magazine to publication.

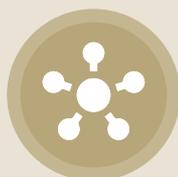
In line with The Framework Document agreed with the Department of Justice this Annual Report commits to providing a summary of the number of complaints received and answered, the principal subjects and the office's success in meeting targets. The report also provides examples of replies given in anonymous form and examples of recommendations made and of responses. Additionally, information is provided where there are any issues of more general significance arising from individual complaints on which the Ombudsman has approached the Prison Service. The Annual Report also provides a summary of costs to the office for the 2021/22 year.

## 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 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 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 5 EFFICIENCY

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



#### 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 Trust to deliver a purposeful, rehabilitative and healthy regime.



#### Principle 6 FORWARD LOOKING

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



## Organisational Structure and Responsibilities

### General

The Prisoner Ombudsman is a public appointee and all other staff are Northern Ireland Civil Service Employees.

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's work and has particular responsibility for corporate governance, process assurance, staff support and delivery of the Ombudsman's strategic objectives. The Director of Operations is also the Budget Manager and has responsibility for day to day running of the organisation.

The Prisoner Ombudsman's Office aims to conduct itself according to best principles and to serve as an example of good management practice. The terms and conditions of staff members are the same as those for the mainstream NICS and the health and wellbeing of staff remains a 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.

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, risk assessments 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 Executive through the Minister of Justice, and acts independently of the Prison Service. The Ombudsman meets regularly with the Trust in respect of death in custody investigations.

Corporate Governance is delivered through quarterly formal meetings with the Strategic Policing Policy and Sponsorship Branch, at which key corporate documents and processes are reviewed. Financial probity is overseen by the Department of Justice (DOJ) Internal Audit Unit. The Office’s accounting information is published in the DoJ finance accounts and is analysed by the Comptroller General of the Northern Ireland Audit Office and an Annual Report is published after the end of each financial year 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.

## Budget Allocation

The 2021-2022 opening budget was £810,000 of which the salary budget was £747,000 (92%).

## Strategic and Business Planning

A 2020-2024 Strategic Plan sets out the vision for the office and focuses on the following four key priorities:

- ▶ Improve investigative processes
- ▶ Safeguard and reinforce independence
- ▶ Prepare for and implement Statutory Footing

Develop a learning environment that puts evidence to work

Progress on the development of the annual 2021-2022 Business Plan which supports these priorities was delayed due to other essential core business activities being prioritised and did not issue until March 2022.



## **Business Continuity and Recovery from Covid-19 pandemic**

The Covid-19 pandemic continued to have an impact on business activities throughout the year as the office implemented its Recovery Plan in adherence with Public Health Agency guidelines and NICS guidance.

Hybrid working arrangements, which were initially introduced as a mitigation to ensure social distancing requirements could be maintained, continue to be operated in the Office. There has now been a wider NICS recognition of the benefits of remote working, and the way we used to work pre-pandemic has transformed.

Specifically, hybrid-working arrangements have become a permanent feature of recovery and post pandemic working. A NICS-wide policy relating to 'New Ways of Working' has formalised these arrangements under which we have directed resources to ensure core office-based business is prioritised. Of particular importance is the maintaining of the Freephone, a vital communication tool for complainants to interact with our office, and a return to normal operating hours has been crucial in instilling a sense of normality for those who use the service.

In its own response to the Covid-19 pandemic the Prison Service had suspended visits to prisons during the previous reporting year in an effort to prevent Covid-19 transmission within the prison environment. A welcome development during 2021-22 was the easing of restrictions in this respect and it is particularly pleasing that Prisoner Ombudsman staff are once again able to have free access to establishments to engage with both those in custody and staff on the ground.

The Office has, over the last few years carried a backlog of investigations in both the Complaints and Death in Custody areas and we had to contend with this even prior to the restrictions placed on us by the Covid-19 pandemic. As a result of not only the pandemic but staff resourcing issues and lack of investigative experience within the office, we have been hampered in making any significant progress in relation to reducing the current backlog of investigations.

One of the main strategic aims of the Prisoner Ombudsman's office is to put appropriate measures in place to ensure that the office is in a state of readiness to achieve Statutory Footing by early 2024. A scoping study had been carried out in 2019 and an updated review, facilitated by the DOJ, completed in March 2022. There are a number of significant actions arising from this review including the development and implementation of a new case management system or alternative that best meets the needs of the office. Efforts will continue with this vital work in the next business year as plans to secure the long-term status of the office gathers pace.



## Staffing

At 31 March 2022 the staff complement comprised the following:

- ▶ Prisoner Ombudsman;
- ▶ Director of Operations;
- ▶ 2 x Senior Investigations Officers;
- ▶ 7.1 x Investigations Officers; and
- ▶ 3.4 x Administrative Support staff.

Both the Complaints and Death in Custody teams were adversely impacted throughout the year by ongoing vacancies and long-term absences. The Director of Operations post also remained vacant until June 2021 when we were able to fill the role via a temporary promotion opportunity. Recruitment of staff continued to be challenging as the office was unable to secure substantive appointments for a number of declared vacancies.

The Complaints team functioned at no more than 50% of normal staffing levels for 8 months of the year and this continued to be the position at year-end. Within Death in Custody temporary promotion arrangements were in place to cover the vacant Senior Investigation Officer position for the entire reporting period meaning that the team were working at 66% of normal complement. Although this arrangement meant that the team were operating under capacity, investigators worked hard to complete 11 investigations.

The work of the Administration team continued to be reliant on the appointment of Agency staff and, due to the level of the vacancies carried, it fell to staff in the Complaints and Death in Custody teams to deliver training to these new and inexperienced staff. We were, however, able to acquire the funding and recruit a new permanent Administrative Officer in June 2021. Overtime costs were met from unallocated salary funds arising from the number of vacancies carried.

Further details of the workloads carried by both teams are outlined below.



## Training

There remains a large level of inexperience within the office and training has been hampered by limitations placed on the office by Covid-19. Desk training could not take place in the comprehensive manner we had hoped for and earlier restrictions on access to prison establishments meant that some newer staff had not yet had an opportunity to experience a prison environment. Training to ensure that those staff fully understood the roles and responsibilities of Prison Service staff, with whom they interact, was commenced towards the end of the year when access to prison establishments was reinstated. This included familiarisation training for staff being commenced within the respective establishments. The Ombudsman also provided training in report writing to Complaints staff in January 2021 and delivered Resiliency training to the wider office in March 2021.

There have been concerted efforts to ensure that all staff have the requisite level of training and expertise needed to carry out their duties. During the course of the year, staff attended awareness sessions that included; understanding the role of a Custody Nurse Practitioner, UK General Data Protection Regulations (GDPR), Prison Service computer systems (PRISM) and the role of the Parole Commissioners for Northern Ireland. Engagement also took place between management and Samaritans in an effort to better understand the respective roles of both organisations within the prison setting.

Specialised investigative training, provided by Bond Solon, was planned for the year but a combination of operational and funding pressures resulted in this being put on hold until the incoming year.

Training and support in family liaison and risk management designed to ensure continued focus throughout death in custody investigations had been planned for staff but has not yet been delivered.

This continued focus on training to address the lack of experience and build up expertise will ultimately enhance standards in the forthcoming year.



## Performance Overview

- ▶ Investigations initiated into the deaths of 3 individuals in custody and 1 Serious Adverse Incident.
- ▶ 11 investigations completed by the Death in Custody team and 5 reports published.
- ▶ 5 recommendations for improvement made in death in custody reports, of which 2 were accepted.
- ▶ 363 individual complaints received which is broadly comparable to the number of complaints received in 2020-2021 (367). Additionally, 74 complaints were considered ineligible upon escalation to our office.
- ▶ 85% of complaints came from Maghaberry Prison (23% from separated landings).
- ▶ 37 (10%) out of 190 complaints investigated were Upheld.
- ▶ 44 recommendations for improvement were made on the outcome of Complaints investigations of which 77% were accepted at time of writing.

We met most standard operational objectives such as conducting complaint and death in custody investigations within our remit and sharing findings with individuals in custody, their families and relevant agencies. However, with Covid-19 restrictions in the early part of the year, operational priorities and the continuing issue of unfilled vacancies, delivery within timescales was not always possible.

### 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.**

It is a source of continuing frustration that, due to resourcing difficulties and operational priorities, we have not been in a position to progress work on placing the office on a Statutory Footing in line with proposed timescales. On a positive note however, we are continuing to work on updating the Terms of Reference for the investigation of complaints. This work is at an advanced stage and will complete in the next reporting period.

**Contribute to Departmental work on regulations for Statutory Footing.**

To date, this work has stalled, but we have committed to working with the Department to set regulations for the move to Statutory Footing.

**Address staffing implications for current Prisoner Ombudsman staff.**

Assessing the staffing structure, roles, skills and development needs required to support the effective operation of the office in preparation for Statutory Footing is an area of work that remains outstanding.



**Deliver all aspects of the new offices remit as provided by Statutory Footing, including name change, rebranding and new website.**

Following the scoping study carried out in 2019, a Departmental led review provided updated recommendations on work required to place the office on a Statutory Footing and this included the rebranding of the office. To date no further work has been completed on this aspect of the review. Work is also to commence on improving the level of information provided in the current website and its format.

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

The development of a communication strategy to promote the new office and the proposed legislative changes remains outstanding.

## 2. Complaints and Death in Custody Investigations

Both the Complaints and Death in Custody teams continue to be under-resourced in terms of staffing. The loss of two Investigation Officers, one to retirement and the other leaving the office on promotion, only served to exacerbate the difficulties being experienced and has had an adverse impact on clearing the backlog of investigations.

**Produce investigation reports that are evidence-based and impartial.**

I acknowledge that opinions about report quality can often be subjective, especially if the evidence is inconclusive. However, where challenges are mounted, we commit to comprehensively reviewing the evidence gathered to ensure adherence to the Prison Rules and our own Terms of Reference.

The "Lessons Learned" process to evaluate all investigations and reports produced, continues to provide a useful quality control mechanism.

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

Internal review and quality assurance of all complaints and death in custody reports produced indicated compliance with the Terms of Reference, especially the important principles of evidence based and impartial practice. Feedback was provided to Investigators both individually and collectively in order to maintain standards and support their professional development. Work has already commenced on reviewing the Terms of Reference for both Complaints and Death in Custody investigations with the aim of having updated Terms of Reference in both areas implemented in the next reporting year.

**Adhere to timescales in all investigations (9 months for draft Death in Custody reports and 18 weeks for final Complaints reports).**

The Death in Custody target was not achieved for any of 5 investigation reports completed throughout the year. Delivering investigations in line with the performance target to issue draft Death in Custody reports within 9 months remains challenging for a variety of reasons including; the ability to complete interviews, the lack of timely responses to requests for information, delays at the factual accuracy stage, the ongoing Senior Investigations Officer vacancy and temporary promotion arrangements with no supporting backfill. Additionally, delays in the Clinical Review process resulting from Covid-19 restrictions and ongoing business recovery have only added to this pressure.

Complaints target not achieved. 57% of all complaints cleared were finalised within the 18-week target. The Complaints team experienced delays in obtaining information and not being able to avail of normal access to prison establishments. A lack of investigative experience and knowledge surrounding the workings of the Prison Service also adversely affected this team's overall performance. Staff training remains a priority and will continue to be in the next reporting period.

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

This on call arrangement was on hold for much of the reporting period due to Covid-19 restrictions put in place by the Prison Service. Under the interim arrangements, when a death in custody was notified out of hours, the on-call IO recorded details of the death before contacting the Ombudsman who, in consultation with senior Prison Service officials, made a decision on whether attendance at prison was required. The Ombudsman agreed to attend any deaths in custody notified out of hours during the night, if required. Of the 5 death in custody notifications received only 3 required a decision on whether attendance at prison was necessary. After consultation, the Ombudsman decided that attendance was not required. Normal on-call arrangements recommenced towards the end of the reporting period after Prison Service restrictions were lifted.

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

Not achieved due to; Covid-19 restrictions, ongoing business recovery, operational priorities and resourcing issues, particularly within the Admin team who carry responsibility for reviewing accepted recommendations.



**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; ongoing Covid-19 restrictions, other operational pressures and staff resourcing issues.

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

Not achieved. We were unable to deliver on outreach efforts due to the Covid-19 restrictions put in place by the Prison Service.

### 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.

**Contribute to relevant consultation exercises, conferences and other events to share the findings of complaint and death in custody investigations.**

No requests received.

### 4. Support for Prison Service & Trust 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.**

Achieved. The purpose of the meetings held throughout the year was to discuss death in custody and complaint findings, address areas of concern and recognise progress.

**Meet regularly with Trust senior managers to share feedback from death in custody investigations and other matters of mutual interest.**

Achieved. The Prisoner Ombudsman met with Senior Trust officials throughout the year and again at interagency meetings which were introduced to facilitate collective discussions around death in custody findings.



**Meet regularly with other stakeholders including CJINI, Independent Monitoring Board, the Coroner, RQIA, ICRC, NIHRC, PBNI, OPO, OPONI, NIPSO to share feedback from investigations and other matters of mutual interest.**

Achieved. Regular meetings took place with stakeholders such as IMB, the Trust, PPO and the Coroner's Office; worthwhile engagements took place with the Scottish Government, NIACRO and the Samaritans.

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

The Ombudsman participated in 5 Prison Service recruit training events throughout the year, including one for Senior Officers.

## 5. Corporate Affairs

**Prepare a 2020-2024 Strategic Plan.**

Achieved. The 2020-2024 Strategic Plan issued in May 2021 and is available [here](#).

**Monitor our financial performance against the opening budget allocation for 2021-2022 of £810,000.**

Achieved. Regular monitoring and reporting to DOJ Finance Services Division and management of finances within allocated budget achieved with no overspend.

**Publish Annual Report by September 2022.**

Not achieved. Publication of the 2021-2022 Annual Report by September 2021 was not possible due to competing operational priorities.

**Issue two editions of 'Inside Issues' magazine to individuals in custody.**

Not achieved. It is disappointing to report that the Inside Issues magazine did not publish during 2021-2022; this was due to focusing on other competing priorities with reduced staff resources.



## Complaints

### Staff Complement

The complaints team continued to operate below staffing complement and for the majority of the year this team was staffed at 50% of its allocated staff complement. This undoubtedly, hampered efforts to, not only clear an already existing backlog of complaints investigations, but also to handle new and incoming complaints within expected timeframes. As a result, the backlog of complaints at the beginning of the year stood at 170 and by year end that figure had increased to 281.

### Review of the Exceptional Assessments & Investigations Process (EAIP) introduced in July 2020

The 2020/21 Annual Report detailed how it was necessary to introduce a more radical approach to managing the backlog of complaints investigations (EAIP). This exceptional process remains in place.

One change introduced following legal consultation, was to remove the option of explanatory letters as a means of responding to a complaint. Previously assessed cases falling under this area were re-assessed either for desktop or full investigation.

Overall, the introduction of the EAIP has proved successful in that it has allowed for a quicker turnaround at the initial assessment stage of a complaint and that investigations are at the appropriate level.

### Prison Service Internal Complaints Process

The Prison Service operates an Internal Complaints Process (ICP) and an individual in custody's right to lodge a complaint to the Prison Service underpins this process. While anecdotal evidence suggests that individuals have mixed views about the effectiveness of the ICP, there appears to be no general reluctance to submit complaints. Our perspective is that an effective ICP is the first cog in a process designed to increase the confidence of individuals in custody in making a complaint about matters affecting them including their welfare and safety. When complaints escalate to my Office it is critical that investigators provide a wholly independent approach and that they take the effectiveness of the ICP into account.

Of a prison population of 1,525 (at 31 March 2022, compared with 1,374 at the same point the previous year) 6,704 complaints were made to the Prison Service during the reporting period, an increase from 6,276 (7%) the previous year. Prison Service data for the period April 2021 - March 2022 shows:



Of the 6,704 complaints made to the Prison Service;

- ▶ 4,898 (73%) were closed at Stage 1
- ▶ 1,495 (22%) were closed at Stage 2
- ▶ 299 (4%) were closed as rejected or upon the complainant's release
- ▶ The remaining 12 complaints were marked as 'open'.

Complaints can only be escalated to my Office when Stages 1 & 2 of the ICP have been completed. At that point there are a number of other avenues for redress open to those in custody, including judicial review and monitoring mechanisms such as those provided by the Independent Monitoring Board.

Separated individuals in custody on Maghaberry Prison Roe House Landings 3 and 4 lodged 121 complaints in the report period, an increase of 31% when compared to 92 complaints received in the previous 12 month period. Of note is the number of complaints closed at Stage 1 of the ICP by those on separated landings (14%) when compared to integrated individuals (73%).

There are various reasons for complaints being closed. These vary from individuals in custody 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 however can be a failure by Prison Service personnel to effectively deal with complaints at the first or second stages of the ICP. Any failure can have a cost to the Prison Service as it may drive further complaints and, when coupled with dissatisfaction, individuals in custody may feel that frustration if they perceive their complaints are not being taken seriously. My Office continues its keenness to work with the Prison Service to ensure good complaints handling and investigation in addition to encouraging an increased focus on resolving complaints at the earliest possible stage.

The Covid-19 pandemic hindered outreach efforts to ensure low user groups, such as foreign nationals, females and young men, were aware of our office and knew how to complain properly. This is something we hope to focus on as society returns to normal.

363 (5%) of the overall complaints made to the Prison Service came to my Office during 2021-2022.



## Complaints received by Prisoner Ombudsman 2021-2022

Of the 363 complaints received, the majority came from Maghaberry Prison as shown in Column 4 of Table 1 below:

**Table 1: Number of individual complaints received during 2021-2022**

Prison	Prison Population	% of total population	Individual complaints	% of all complaints
Maghaberry -Roe 3 & 4 Separated Individuals in Custody	30	2%	85	23.4%
*Maghaberry -others	951	62%	223	61.4%
Magilligan	415	27%	45	12.4%
Hydebank Wood (young men)	58	4%	1	<1%
Hydebank Wood (female)	71	5%	9	2%
<b>Overall Total</b>	<b>1,525</b>	<b>100%</b>	<b>363</b>	<b>100%</b>

### Integrated Individuals in Custody (i.e. those in general prison population)

Overall complaints received were analogous to the 2020/21 year; 278 compared to 275 the previous year. This represents just over 4% of all complaints initiated via the Prison Service internal complaints process (6,704), which again is comparable to last to the 2020/21 figures (6,276).

The low number of complaints from young men and women in Hydebank Wood College and Women's Prison remains a matter of concern, however, a number of factors must be taken into account when analysing these statistics not least the different types of prison environment and the specific needs of the individuals in custody in their respective care. As before, we will continue to monitor and consider how the Office ensures individuals in custody are aware of and understand how to make a complaint to my Office.



### Separated Individuals in Custody (those who have met the criteria for separated status)

Separated individuals in custody held on Roe House 3 & 4 landings at Maghaberry Prison lodged 85 individual complaints in the report period, compared to 92 in the previous year (a slight decrease). No complaints from Bush House separated landings were escalated to our office during the same period.

Although the number of separated individuals in custody represent just under 2% of the total prison population, overall 23% of the complaints received were from individuals in this category.

### Complaints handling April 2021 - March 2022

Table 2 sets out the numbers of complaints cleared by the Office during the period April 2016 - March 2022. The number of complaints cleared during the current year decreased by 218 overall from 454 in the previous year to 236 (%). Broken down, 190 cases were investigated, there were 18 complaints closed by way of local resolution and the number of cases withdrawn was 28. Much of the differential in the overall reduction in cleared complaints is attributable to the fact that we were able to avail of additional temporary resources in 2020/21 which increased output for that year and, for the current period, the impact of operating for much of the year with a staff resource deficit. The latter has hindered our ability to clear complaints as quickly as we would have liked.

**Table 2: Complaints cleared April 2016 - March 2022**

Year	Investigated & Reported	Local Resolution	Withdrawn/ Released	Total
<b>2021- 22</b>	190 (80.5%)	18 (7.6%)	28 (11.9%)	236
<b>2020- 21</b>	391 (86%)	6 (1%)	57 (13%)	454
<b>2019- 20</b>	134 (65%)	16 (8%)	56 (27%)	206
<b>2018-19</b>	275 (82%)	2 (<1%)	60(18%)	337
<b>2017-18</b>	252 (81%)	13 (4%)	47 (15%)	312
<b>2016-17</b>	220 (72%)	4 (1%)	84 (27%)	308



Table 3 provides a breakdown of outcomes for the complaints investigated and reported on by this Office and allows for comparison of between years.

**Table 3: Outcomes for Complaints Investigated April 2016 - March 2022**

Year	Upheld	Partially Upheld	Not Upheld	Total
<b>2021 - 22</b>	37 (19.5%)	0 (0%)	153 (80.5%)	<b>190</b>
<b>2020 - 21</b>	23 (6%)	8 (2%)	360 (92%)	<b>391</b>
<b>2019 - 20</b>	31 (23%)	11 (8%)	92 (69%)	<b>134</b>
<b>2018 - 19</b>	49 (18%)	45 (16%)	181 (66%)	<b>275</b>
<b>2017 - 18</b>	46 (18%)	108 (43%)	98 (39%)	<b>252</b>
<b>2016 - 17</b>	39 (18%)	45 (20%)	136 (62%)	<b>220</b>

There are a number of underlying themes behind complaints that come to my Office not least, issues with incoming and outgoing mail processes, lengthy lock-ups due to staffing problems within the Prison Service exacerbated by the Covid-19 pandemic and loss of property. The significance of the issues facing those in custody should not be understated.

44 recommendations for improvement in response to complaints made by individuals in custody during the year were made of which 34 (77%) were accepted and 10 (23%) were rejected.

Table 4 provides an analysis of the range and nature of complaints received from those in custody in Maghaberry Prison from which the majority of complaints arise.

**Table 4: Maghaberry Integrated population Main Complaint Topics 2016-2022**

Complaints Topic	2021-22	2020- 21	2019- 20	2018-19	2017-18	2016-17
<b>Staff attitude</b>	56	41	35	50	26	33
<b>Accommodation</b>	19	19	12	23	12	11
<b>Property and Cash</b>	36	19	18	15	24	16
<b>Adjudications</b>	2	1	5	15	5	7
<b>Tuckshop</b>	8	0	4	11	-	-
<b>Complaint Procedure</b>	16	17	4	9	-	-
<b>Mail</b>	10	13	2	8	7	4
<b>Discrimination</b>	6	4	2	8	2	4
<b>Visits</b>	4	8	5	7	7	5
<b>Searching</b>	4	2	4	7	2	1
<b>Transfers/Allocation</b>	9	6	1	6	6	7
<b>Regime</b>	6	7	2	6	6	7
<b>Adverse reports</b>	4	12	3	5	2	2
<b>Food</b>	3	0	2	5	-	-
<b>Telephone</b>	9	3	6	5	-	-
<b>Lock down</b>	2	0	0	4	1	7
<b>Education</b>	0	0	2	2	6	6
<b>Health &amp; Safety</b>	1	5	3	1	3	1
<b>Home leave</b>	3	0	4	-	1	-
<b>Miscellaneous</b>	32	24	24	33	38	58
<b>TOTAL</b>	<b>230</b>	<b>181</b>	<b>138</b>	<b>209</b>	<b>148</b>	<b>169</b>



The nature of the 32 miscellaneous complaints received can be further broken down as follows:

**Table 5: Breakdown of 32 miscellaneous complaints received during 2021-22**

Complaint Topic	Number of Complaints Received	Complaint Topic	Number of Complaints Received
General conditions	1	Night Procedures	3
Programmes	3	Pre-Release	2
Work Allocations	3	Probation	1
Alleged Assault	3	Association	2
Alleged Harassment / Bullying	4	Rule 32	1
Coronavirus	1	Drugs	1
FOI	1	Foreign National issues	1
Links	1	PREPS	1
Programmes	3		



## Complaint Case Studies

**Mr A** submitted a complaint via the Internal Complaints Process (ICP) alleging that the conditions under which he had to live when housed in Care and Supervision Unit (CSU) were substandard. Mr A's placement in CSU followed an alleged assault on staff.

An investigation into the complaint took place with all relevant records obtained and policies reviewed. My investigator assessed each of the individual issues raised by the complainant separately and established that in relation to the majority of allegations there was evidence that the Prison Service had acted reasonably and fairly.

In my report, I reminded the Prison Service of the importance of good record keeping, particularly in circumstances where there are significant areas of disagreement or where after a review of relevant logs, certain aspects of the complaint remained unsubstantiated.

*Complaint not upheld.*

**Mr B** complained about Prison Service staff opening his legal mail before he received it.

The item in question was a letter from his solicitor and was clearly marked with the appropriate legal correspondence code. Upon being handed to Mr B it was clear that the letter had been opened and resealed with cellotape which was confirmed by the Prison Service. Letter Censors contested that Business Services within the prison establishment might have inadvertently opened the item.

The Investigating Officer carried out a thorough investigation which included not only reviewing the Prison Service policies on legal mail but a visit to Letter Censors to familiarise themselves with the processes involved in the handling of such sensitive correspondence.

In my report, I highlighted that the Prison Service should review how they record their processes when staff open mail incorrectly and that retraining of staff should take place, if necessary.

*Complaint upheld.*



**Mrs C** made a complaint to our office in relation to virtual visits.

The Prison Service had made a corporate decision to change the platform used for virtual visits in light of the Covid-19 pandemic. This new interface was introduced in all establishments, however, Mrs C expressed concern that there would be less availability for those in custody to maintain family links in the manner that they had become accustomed to.

The Investigating Officer spoke with the complainant and senior Prison Service staff to establish the new arrangements and concluded that fairness standards had been adhered to by the Prison Service. They also confirmed that the availability of the new facility was in adherence with Prison Rules in terms of amount/duration of weekly virtual visits and also provided assurance that additional visits could be facilitated at the Governor's discretion.

*Complaint was not upheld.*

**Mr D's** complaint related to the loss of property and cash upon his return to prison following home leave.

On receipt of the complaint the Prison Service carried out a thorough search for the missing items and the Investigating Officer acknowledged that considerable time and effort was applied to locate the missing items.

However, following a lengthy and comprehensive investigation carried out by our office it was clear that the Prison Service had kept insufficient records from the outset which exposed gaps in the timeline and made the initial internal search all the more difficult.

As a result *Mr D's complaint was upheld*; I recommended in my report that recording procedures for the processing of property following periods of home leave/temporary release should be reviewed to ensure that they are robust and accurate.

The Prison Service accepted this recommendation and carried out a full review of current practice whilst also acknowledging that the committal procedure had necessitated temporary change during the Covid-19 pandemic.



**Mr E** submitted 2 x Freedom of Information requests and, subsequently, submitted a complaint as he had received no response to either.

Following investigation my Investigating Officer concluded that the Prison Service fell short of meeting their legislative obligation to respond within the timelines set out in FoI legislation. This represented a serious failing, and the fact that requests were neither monitored nor expedited would indicate that a proper system for doing so either did not exist or was not applied. Additionally, the Investigating Officer found that the responses provided by the Prison Service under the ICP were not helpful in resolving the matter.

Consequently, *my office upheld Mr E's complaint* and in my report I recommended that (a) Mr E be issued with a formal written apology; (b) the Prison Service Record & Information Management Team should issue a Notice to Staff informing all those who might be dealing with Freedom of Information requests of the required response times and where the FOI guidance can be accessed and; (c) The Prison Service Records & Information Management Team liaise with the DOJ Information Manager to ensure that a system is in place to properly log and monitor FOI requests in order to prevent such a serious breach reoccurring.

The Prison Service accepted all 3 recommendations.

**Mr F** complained that the Prison Service had refused him a clothing parcel on the basis that there were items contained on the clothing card that were not in Mr F's possession and no satisfactory explanation could be provided as to their whereabouts other than they had been disposed of.

My Investigating Officer carried out an investigation which included a review of Prison Service policies and procedures surrounding clothing cards and additionally considered the contents of the individual's clothing card, and found that the delay in granting the clothing parcel was due to Mr F's failure to comply with the correct process for disposing of clothing. His clothing card was updated and he, subsequently, received the requested parcels.

*Mr F's complaint was not upheld.*



## Deaths in Custody

Ombudsman investigations into prison deaths are part of a three-pronged process by which the state fulfils its duty under Article 2 of the European Convention on Human Rights (the other elements being a police investigation and the Coroner's inquest). This process ensures that every aspect of an individual in custody's death is explored.

During 2021-22, 5 notifications were received of which 3 related to deaths in custody and 2 related to serious adverse incidents. Arising from this, 4 investigations were initiated, 3 in Maghaberry Prison and 1 in Hydebank Wood College. We received the notifications relating to the deaths in custody in June 2021(2) and February 2022 (1) respectively. All 3 deaths appeared to be self-inflicted and Inquests for each to establish the actual cause of death are pending. In line with established practice, not all SAIs reported necessarily require investigation on my part. Although 2 notifications concerning Serious Adverse Incidents (SAI) were reported separately in July 2021 and August 2021, the Prison Service requested that only 1 of these be progressed to investigation. The number of deaths notified this year has decreased by 2 (40%) when compared to the previous year. Additionally, 2 Serious Adverse Incidents were notified this year compared to none in the previous year.

No post-release deaths were notified this year compared to 4 notified the previous year.

Although Covid-19 restrictions and the subsequent environment of recovery continued to hamper investigative actions, the Death in Custody team successfully completed 11 investigations during the reporting period, specifically 5 Deaths in Custody and 6 post-release deaths. This was a significant achievement in light of restrictions faced and a reduced staff complement. Reports were published in for the 5 deaths in custody investigations and concerned 3 self-inflicted deaths and 2 from natural causes. The published reports contained 5 recommendations for improvement, 1 for the Prison Service, 3 for the Trust and 1 joint recommendation for both the Prison Service and the Trust. 3 out of the 5 recommendations were not accepted (2 by Trust and the joint recommendation). As with the previous year, the Prison Service did not report any Covid-19 related deaths to my Office during 2021-2022. I commend the stringent efforts made by both the Prison Service and the Trust to minimise Covid-19 occurrences within the prison environment throughout the pandemic.



As at 31 March 2022, the Death in Custody team carried an outstanding caseload of 18 cases broken down as follows:

- ▶ 15 live investigations (14 Deaths in Custody and 1 SAI), and
- ▶ 3 cases (where the investigations had been completed) requiring Disclosure action for the Coroner.

Interagency meetings continued throughout the year in an attempt to make effective recommendations and to speed up factual accuracy timeframes in death in custody investigations. Work continues in terms of improving the overall effectiveness of these meetings, which to date have been well received and have facilitated learning between our partners as well as learning for us.

## Comparisons to other Jurisdictions

### England & Wales:

The Ministry of Justice's "Safety in Custody Statistics Bulletin" issued on 28 July 2022 states that in the 12 months to June 2022, there were 288 deaths in prison custody, an decrease of 27% from 395 deaths in the previous 12 months. Of these, 66 deaths were self-inflicted, a 20% decrease from 82 self-inflicted deaths in the previous 12 months.

### Scotland:

Figures provided by the Scottish Prison Service suggest that there were 53 Deaths in Custody in 2021, an increase from 34 in 2020.

### Republic of Ireland:

The Annual Report of the Office of the Inspector for Prisons for 2021 shows that 8 deaths were reported the period 1 January to the 31 December 2021 in the Republic of Ireland. This was a decrease from 13 the previous year.



## Corporate Affairs

### External Communication

The Prisoner Ombudsman's 2020-24 Strategic Plan sets out the strategic priorities the Ombudsman aims to achieve. The Plan issued on 8 May 2021 and is available to view on our website by clicking [here](#).

Publication of 5 of the death in custody reports accompanied by a press release and where appropriate, supplementary communications activity.

Regular contact was maintained with other external stakeholders including; NIACRO, PPO, the Coroner's Service, Samaritans, Forensic Mental Health, RQIA, CJINI, Scottish Government, Independent Monitoring Board and ICRC.

Regular engagement also continued with the Prison Service including the delivery of training sessions with new recruits to inform and raise awareness of the role of the Ombudsman. Monthly stock take meetings with the Prison Service Director-General continued as normal.

Staff availed of a number of awareness sessions where we had the opportunity to learn more about the roles and responsibilities of some of our external stakeholders. These included:

- ▶ In February 2022, nursing staff from PSNI Musgrave Street Custody Suite delivered an information session on the new role of the Custody Nurse Practitioners.
- ▶ In October 2021 staff from the Parole Commissioners for Northern Ireland (PCNI) also visited our office to deliver an information session on their role in assessing individuals in custody for release and recall.

Interagency meetings continued in death in custody investigations.

Quarterly governance meetings with DOJ staff took place.

We also continue to attend and contribute to a number of forums on a regular basis specifically; DOJ Procurement, Security Managers and Finance forums.

"Inside Issues," a four-page newsheet is the Office's main vehicle for communicating with individuals in custody. It includes case studies, statistics and information about the complaints process in eight languages and a copy distributed to each person in custody at the time of issue. Unfortunately, 'Inside Issues' did not publish during 2021-2022.



## Finance & Accountability

The Prisoner Ombudsman's opening budget for 2021-22 was £810,000. The Office complies with the Department of Finance's Managing Public Money NI guidance and with the principles governing relationships between departments and their Arms' Length Bodies. To this end, a Framework Document sets out the relationship with the DoJ.

This 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 accounts for its performance.

The Prisoner Ombudsman's Office receives funding directly from DoJ Programme funds rather than by grant-in-aid. As such, any expenditure incurred by the Office is recorded as part of DoJ departmental expenditure. This means the Office does not produce its own set of accounts nor lay its finances before the Assembly separately from the DoJ.

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

Quarterly overview meetings continued with the Department.

All proposed business changes were set out 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 the Department of Finance Construction and Procurement Delivery (CPD) guidelines and approvals processes. The Office Manager 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 for the duration of contracts, the supplier delivers quality and services to standard and that evaluation takes place.



## Information Security

The Director of Operations manages Information Security, which aligns 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. All Staff receive appropriate training and are 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. The Senior Management Team regularly assess the Risk Register and a system of internal control provides proportionate and reasonable assurance of effectiveness in line with identified risks. The Senior Management Team oversees the management of internal controls together with risk management and regularly reviews their effectiveness.

## Shared Services

Corporate shared services include:

- ▶ NICS HR and NICS HR Connect services have provided Payroll and Human Resources support since April 2010;
- ▶ Finance transactional support functions have been provided via the Account NI shared service system since July 2012; and
- ▶ DOJ Financial Services Division provide retained finance functions.
- ▶ 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.