

Criminal Justice Inspection
Northern Ireland
a better justice system for all



PRESENTATION TO HYDEBANK WOOD MANAGEMENT TEAM

15 April 2010



AGENDA

- Background and objectives of CJI;
- purpose of prison inspection and what does success look like; and
- case study – vulnerable prisoners inspection.



SOME BACKGROUND...

- Criminal Justice Inspection Northern Ireland (CJI) is an independent, statutory inspectorate established in 2003 under s.45 of the Justice (Northern Ireland) Act 2002. It is a Non-Departmental Public Body (NDPB) in the person of the Chief Inspector.
- CJI is one of a kind as it is the only unified inspectorate in the United Kingdom or Ireland that can look at all the agencies that make up the CJS, apart from the Judiciary. Agencies which CJI can inspect include the police service, prison service, prosecution service, youth justice services and the courts.
- This means CJI is in a unique position to identify issues that are common to some or all agencies and is in a strong position to promote inter-organisational learning and best practice across and between the various agencies.



OUR OBJECTIVES ARE...

- Promote efficiency and effectiveness through assessment and inspection to facilitate performance improvement;
- provide an independent assessment to Ministers and the wider community on the working of the CJS;
- provide independent scrutiny of the outcomes for, and the treatment of, the users of the CJS; and
- work in partnership to deliver a high quality independent and impartial inspection programme.



IN RELATION TO PRISONS THIS MEANS...

- Announced and unannounced inspections of individual establishments (for example Maghaberry inspections 2006 and 2009);
- specific inspections of the NIPS as an organisation (for example Prison Officer Training);
- inspection of the NIPS as part of a more thematic look at the NI justice system (Lifer Management, S.75 reports).

In understanding our inspection programme we work closely with other organisations that can provide specialist support and benchmarking information on performance. More explicitly establishment inspections are undertaken jointly with HMIPrisons – prisons here are inspected in the same way as other prisons in England and Wales.



PRISON INSPECTION BASED ON 'HEALTHY PRISON' CONCEPT

- World Health Organisation tests of what constitutes a healthy custodial environment; Council of Europe and UN Human Rights Legislation.
- Four tests:
 - prisoners should be held safely;
 - treated with respect;
 - able to engage in purposeful activity; and
 - prepared for resettlement.



THE PURPOSE OF A PRISON INSPECTION IS TO CONSIDER THE OUTCOMES FOR PRISONERS

- The assessment as to whether a recommendation has been achieved is dependent on whether **it has delivered on the ground** – what difference has it made?
- While account is taken of work in progress it is only relevant **IF it has achieved real change** – for example, in Maghaberry 54% of recommendations had been assessed as not achieved in this way.
- Follow-up reviews are an important tool in determining the extent of achievement – **focus on achievement.**



LOOKING AT SPECIFIC RECOMMENDATIONS THE FOCUS IS ON DELIVERY... THIS IS WHAT SUCCESS LOOKS LIKE FOR US (from HBW 2008 Inspection)

- The reception area should be redesigned and refurbished to provide an appropriate environment to meet the needs of young people arriving in custody;
- a personal officer scheme should be established to support young people, liaise with families and encourage effective resettlement;
- NIPS should either remove young men under the age of 18 from HBW or provide appropriately resourced, dedicated accommodation with a regime capable of meeting the needs of this population;
- an education and training policy for young people should be developed that provides sufficient work and education places to keep all young people purposefully occupied;
- implementation of a diversity strategy and provide relevant staff training in religious and cultural differences; and
- all young people should have at least 10 hours out of their cells on weekdays.



DELIVERING REAL OUTCOMES... AS IDENTIFIED IN HMIP 'EXPECTATIONS'

- **Duty of care** – “everyone feels safe from bullying and victimisation... active and fair systems to prevent and respond to violence and intimidation are known to staff, prisoners and visitors...”
- **Self-harm and suicide** – “Prisons work to reduce the risks of self-harm and suicide through a whole prison approach. Prisoners at risk of self-harm or suicide are identified at an early stage and a care and support plan is drawn up, implemented and monitored. Prisoners who have been identified as vulnerable are encouraged to participate in all purposeful activity...”
- **Learning, skills and work activities** – “... prisoners are encouraged and enabled to learn both during and after sentence, as part of sentence planning, and have access to good library facilities. Sufficient purposeful activity is available for the total prisoner population.
- **Time out of cell** – “All prisoners are actively encouraged to engage in out of cell activities and the establishment offers a timetable of regular and varied extra mural activities.
- **Security and rules** – “Security and good order are maintained through positive staff-prisoner relationships based on mutual respect, as well as attention to physical and procedural matters”.



CASE STUDY – VULNERABLE PRISONERS

- NIPS has worked to ensure that the service failures identified in the death of Colin Bell will not be repeated in any further death in custody. The Service has taken steps in reducing the negligence and system failures identified.
- While the Service has addressed many of the immediate issues there remain significant concerns around the development of a more suitable regime for vulnerable prisoners, particularly in Maghaberry Prison. Little appears to be changed since the January 2009 inspection.
- During our inspection questions were raised around the operational priority given to the REACH landing despite the stated management objective of improving the quality of service provided.
- Staff are well aware of the risks within the prison – prisoners have yet to see the difference in terms of their experience.



SAFER CUSTODY DEVELOPMENTS

- Clarity around objectives and statement of purpose for REACH (April 2009).
- More strategic approach to safer custody within the service – role of safer custody staff.
- Evidence of PO's actively managing staff, analysing PARI and challenging behaviours.
- SPAR Pilot commenced – early stages.
- Prisoner engagement through Listener Scheme and attendance at meetings.
- Some excellent and committed staff who have made a difference to the treatment of prisoners.
- Women's strategy when delivered will make a difference.



IMPLEMENTATION OF PRISONER OMBUDSMAN RECOMMENDATIONS

- CJI's assessment indicates:
 - 21 recommendations are 'achieved';
 - 16 are 'partially achieved'; and
 - 6 are 'not achieved'.
- Key messages:
 - good progress in some key areas;
 - most progress also has been made in relation to 'policy' initiatives (66% achieved compared with 39% of 'operational' issues);
 - least progress made in the care of vulnerable prisoners.



RANGE OF ISSUES IMPACTING ON VULNERABLE PRISONERS

- Insufficient psychologist input into case conferences and care plans;
- Core regime for vulnerable prisoners impacted negatively by wider management pressures:
 - population pressures on REACH / Lagan (sex offenders, Lifers, Foreign Nationals etc...)
 - safe staffing levels – priority given to REACH;
- PoA Action significant impediment to regime change over last six months;
- Limited regime change – too much time in cell for vulnerable prisoners (for example 17% use of the garden);
- No co-ordination of individualised care plans for vulnerable prisoners;
- Service remains individualised – good practice often dependent on specific individuals who want to make a difference;
- Therapeutic approach not engrained
 - Cynical attitudes remain
 - Security focus
 - Staff not engaged with care of prisoners;
- “one size fits all” approach to vulnerable prisoners – complexity of Lagan Population.



SOME COMMENTS ON HBW

- Action plans prepared at HQ level – insufficient ownership at establishment level;
- lack of personal officer scheme;
- quality of some safer custody meetings could be improved;
- access to work, education and other positive activities insufficient;
- examples of poor recording of information – files did not reflect reality of situation;
- establishment of safer custody teams recognised;
- development of prisoner forum and prisoner surveys;
- improved frequency of case conferences;
- dry run tests to establish staff response times; and
- evidence of self audit and sharing of good practice.



WHAT DOES THIS MEAN MOVING FORWARD?

- Turning policy into reality – saying it / writing it, does not make it so – beware of ‘virtual prison’;
- prioritisation on what will make a difference – if everything is a priority nothing is; and
- taking a wider view on the obstacles to change and what needs to be done to overcome them – are we tackling the right issues to achieve change or going around the margins?



ACHIEVING MEANINGFUL CHANGE WILL REQUIRE...

- Leadership, building management capacity and accountability;
- focus on delivery – clarity about what needs to be done and making it happen, and challenging the status quo to make it happen; and
- understanding and achieving the outcomes expected (quick wins) – building on success.



CONCLUDING REMARKS

- Examples of good practice identified in Magilligan and Hydebank Wood and on an individual basis in Maghaberry;
- we would question how much has changed in the outcomes for prisoners in Maghaberry since the January 2009 CJI / HMIP inspection; and
- immediate risks associated with the death of Colin Bell addressed BUT improvements in therapeutic regime for prisoners more limited.



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