**Statement from Brendan McGuigan, acting Prisoner Ombudsman for Northern Ireland**

**September 2018**

“Since September 2005 the office of the Prisoner Ombudsman has investigated the circumstances surrounding the deaths of 56 prisoners which occurred either while they were in prison custody or just after their release. The office was also notified and reviewed the circumstances surrounding the deaths of 21 people who died shortly after their release from custody and investigated 22 three serious self-harm incidents. On each occasion each death has represented the loss of a family member, friend or loved one.

“Investigations into deaths which occurred in custody or those which occurred within fourteen days post custody are undertaken to establish the circumstances and events surrounding the death including the care provided by the Northern Ireland Prison Service (NIPS). They also examine relevant healthcare issues and assess the clinical care which was provided by the South Eastern Health and Social Care Trust (SEHSCT).

“In addition, they provide families with an opportunity to raise any concerns they may have had concerning the death of their loved one, so that these issues are taken into account as part of the independent investigation and seek to assist the coroner in carrying out their responsibilities.

“The reports and the recommendations made as a result of the investigation are intended to ensure all those with responsibility for caring for men and women held in custody learn from these tragic incidents and work to ensure prisoner safety.  They also aim to assist the prison service and trust to make changes, where possible, that could help prevent a similar death occurring in the future.

“I acknowledge that the NIPS and SEHSCT have demonstrated their willingness to work to improve prisoner safety by accepting the recommendations made as a result of death in custody investigations. However it is a matter of concern that recommendations which have been accepted have not been implemented and on many occasions, recommendations have been repeated.  This is an issue which my predecessor Tom McGonigle raised with the then Ministers of Justice and Health in November 2014.

“While both ministers responded positively, since that time a further 13 death in custody investigation reports have been published by this office. Out of the 195 recommendations made within those reports, 173 were accepted and included 42 recommendations which had previously been made and accepted.

“The lack of progress in implementing some of the recommendations made by the office of the Prisoner Ombudsman has also been raised as a concern by Criminal Justice Inspection Northern Ireland – most recently in August 2017 when the latest ‘ light touch’ review of Maghaberry Prison was published.

“I believe a process now needs to be put in place which ensures the recommendations made as a result of death in custody reports are fully addressed, and that this approach is applied both at a strategic and operational levels within the prison service and South Eastern Trust.

“It is incumbent upon all those charged with keeping people safe while in custody, many of whom are vulnerable, to ensure progress is made in this key area and that accepted recommendations made as a result of death in custody reports are implemented.”