A follow-up inspection of Northern Ireland Prison Service mistaken prisoner releases

March 2012

Criminal Justice Inspection
Northern Ireland
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List of abbreviations

CJI	Criminal Justice Inspection Northern Ireland
ICOS	Integrated Court Operation System
NICTS	Northern Ireland Courts and Tribunals Service
NIPS	Northern Ireland Prison Service
PECCS	Prisoners Escort and Court Custody Staff
PSNI	Police Service of Northern Ireland
PRISM	Prisoner Records Information System Management
SEE	Strategic Effectiveness and Efficiency (Programme in the NIPS)

Chief Inspector's Foreword

In November 2010 Criminal Justice Inspection Northern Ireland (CJI) reported on oversight of the Northern Ireland Prison Service (NIPS) enquiry into the erroneous release of two prisoners. One of the recommendations of that report was to carry out a follow-up inspection to monitor and review the implementation of recommendations made in the NIPS internal enquiry. This follow-up inspection reports predominantly on the implementation of those NIPS recommendations.

Since publication of the CJI report in November 2010 there have been a further four erroneous releases. The first occurred on 24 November 2010 (Prisoner A), and a further on 24 June 2011 (Prisoner B). Another mistaken release took place on 7 November 2011 (Prisoner C) and the last such mistaken release occurred on 8 February 2012 (Prisoner D), bringing the total to six in the period since September 2010.

With regard to these further mistaken releases, in summary, Prisoner A was released primarily as a result of computer error - the details which were input had only partly loaded creating confusion as to release sequences. The NIPS internal enquiry into this specific release concluded that the remedial actions put in place following the release of the first two erroneous releases, would not have prevented this mistaken release. Prisoner B was released primarily as a result of human error in both sentence calculation and validation checks. The systems, if correctly applied, should have been capable of preventing this mistaken release. The fifth release (Prisoner C) occurred on 7 November 2011. This resulted from incorrect data supplied by the Northern Ireland Courts and Tribunals Service (NICTS) and is not considered an error attributable to the NIPS. The final release occurred on 8 February 2012. An internal NIPS investigation has been launched into the circumstances, the outcome of which was not known at the time of writing. However, Inspectors understand that this is likely to be a case of human error.

Inspectors also understand that in the case of each of the erroneous releases, the persons concerned have either been returned to prison, or their penalties have otherwise been discharged. In the case of all those releases, with the exception of Prisoner C, the NIPS conducted its own internal investigation which followed the NIPS code of conduct and discipline. In the case of Prisoner B a number of staff including three Governor grades have been served with disciplinary papers. To that extent, the NIPS have complied with CJI's recommendation that such enquiries should follow procedure for regulation and control.

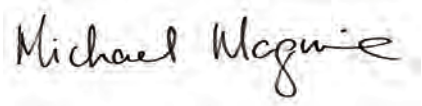
As part of their follow-up, Inspectors asked the NIPS to conduct a self-assessment of progress against the recommendations. Inspectors also undertook a series of further validation checks and meetings with Prison Service staff. This entailed an Inspector conducting a number of meetings with senior NIPS staff, visits to Maghaberry and Hydebank Wood prisons, as well as visiting Prisoners Escort and Court Custody Staff (PECCS) at Downpatrick Court. Inspectors work also incorporated a review of NIPS discharge files.

Inspectors acknowledge that much work has been completed or commissioned by the NIPS. Significant effort and finance had, for example, been expended on IT solutions. It was also apparent that a root and branch review of the processes involved in prisoner committal and discharge processes had been initiated. A consultancy service had been engaged for this purpose, and this decision was taken in order to conduct a more fundamental assessment and review, rather than continuing to implement incremental change. Inspectors considered however, that the NIPS Senior Management approach, while understandable in many respects, lacked concentration on the pressing risks and performance gaps. Work had focussed on longer term process re-engineering, and fundamentally neglected the immediacy of the ongoing risks.

Inspectors also concluded that the pace of change, balanced against the associated risks, required a more expeditious approach to some of the outstanding recommendations. This included, for example, policy and procedural guidance, as well as staff training and the project management required to ensure delivery. Consequently, in October 2011, Inspectors provided early feedback to the Director General of the Prison Service. This resulted in additional focus and resources being applied. In addition, the NIPS then linked the issue of erroneous releases to the Strategic Effectiveness and Efficiency (SEE) Programme overseen by the Director General.

Inspectors can now report that of the 25 NIPS recommendations, 14 (56%) can now be said to be met in full. A further 10 (40%) can be said to be partly completed and one (4%) as discharged (no longer relevant).

Despite this positive progress, Inspectors remain disappointed at the overall pace of change. For example, it is disappointing that formal training for front line staff has still not been delivered and that well over one-third of the recommendations made have not been met in full some 15 months after the first report. Also, the need for a continued focus on the full implementation of existing controls by way of supervision and quality checks, is manifestly demonstrated by the most recent mistaken release in early February 2012. However, Inspectors make clear that even when all recommendations are implemented in full, the risks of erroneous releases cannot be entirely eliminated. While it is clear that the NIPS have now committed to embed the strategic changes necessary to bring the risks under control, the spotlight must be maintained on compliance and with ongoing quality assurance. This is especially important at a time of major strategic change in the NIPS. Taking account of work yet to be completed, there clearly remains some way to go before the realisation of a fully proficient and assured system. Thus, the challenge moving forward is to ensure that the changes and practices underpinning the changes made (and proposed), become entrenched at operational level. At strategic level, the issue of erroneous releases should continue to be managed as part of the SEE Programme, and also as part of the organisational risk register. In short, both operational and strategic focus needs to be maintained on the issues, and ultimately, the expeditious completion of all the outstanding recommendations.



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March 2012

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Section 1

Follow-up Review

CHAPTER 1:

Introduction

1.1 This report describes the CJI follow-up to its November 2010 report on the mistaken release of prisoners by the NIPS, and particularly on progress in the implementation of the 25 recommendations made by the Prison Service to address the risks. In it's own enquiry report into the mistaken releases prior to October 2010, the NIPS made a total of 25 recommendations. These recommendations were agreed and supported by Inspectors, who at the time in publishing their own report commented *'... the NIPS enquiry delivered what was required... and identified or instituted fitting remedial actions to moderate the risk of occurrence of any erroneous releases in the short-term.'*

1.2 At the time of the original 2010 inspection there had been two mistaken releases. However, since that time a further four mistaken releases have occurred, and it was in light of the continuing mistaken releases and public concern with regard to them, that this follow-up inspection took place. In simple terms, Inspectors were aware and concerned that the risks appeared to be increasing rather than, as might have been expected following previous reports and concerns, decreasing.

1.3 The first of the subsequent four known erroneous releases occurred almost immediately after the publication of the CJI report on 24 November 2010. This resulted from the Prisoner Records Information System Management (PRISM) failures insofar as details which were input only partly loaded creating confusion as to release sequences. In this case the remedial actions recommended, following the original erroneous releases, would not have prevented such an occurrence. The second occurred on 24 June 2011. This was a case of human error alone resulting from a mistake in sentence calculation. While sentence calculations can be complex in some cases, this particular case was not so. This mistaken release further flagged the issue of custom and practice in the final release checks conducted by Governors. In this case while the release had been authorised by a Governor, independent checks/calculations had not been done. The third release occurred in November 2011 when a fine default prisoner was release three days early. This latter release occurred due to inaccurate recording by the NICTS. The final release occurred on 8 February 2012. An internal NIPS investigation has been launched into the circumstances, the outcome of which was not known at the time of writing.

The scale of the problem

1.4 While any erroneous release is concerning and has the potential to create reputational risk, it is more concerning when a potential risk to public protection exists, as may be the case in any erroneous release. However, the NIPS is conducting some 370 discharges per calendar month. That equates to approaching 4,500 releases each year. While the goal must be to achieve 100% accuracy, it will be unrealistic to expect (given the variables and complexities involved), that this will be achieved year on year. Nonetheless, six such releases in a short period of time must be regarded as unacceptable, and therefore everything possible must be done to avert further mistaken releases.

1.5 In terms of comparisons Inspectors have calculated that the current numbers of mistaken releases in Northern Ireland over the 12 month period from November 2010 to November 2011, (four) equates to some 0.26% of the average prison population (1,500). The comparative figure for England and Wales was 63 mistaken releases in 2009-10 set against an average population there of 85,000, and thus giving a rate of 0.07%. Inspectors point out that while any mistaken release is unacceptable and has potential community safety issues attaching, the Northern Ireland rate of mistaken releases, while higher than in England and Wales, is not substantially so.

CHAPTER 2:

Follow-up findings and conclusions

Progress since initial inspection

2.1 As part of the follow-up the NIPS was asked to complete a self-assessment of progress and this was received by Inspectors in September 2011. Inspectors also asked what internal quality assurance had been conducted on the work completed, and were provided with the report of an internal audit. In early 2011 the NIPS had appointed their Head of Standards and Audit to conduct a review of progress. A report was compiled in April 2011 setting out progress and highlighting continuing areas of concern. Inspectors have been provided with, and examined that report, which concluded as follows:

- a significant amount of work had been completed to correct some but not all of the issues identified in the original enquiry;
- considerable risks still remained;
- there was a general lack of confidence amongst some staff exacerbated by the absence of formal training and induction;
- there was a general absence of strategic or generic policies regarding the functions of the general office which is responsible for administering the discharge process; and
- Duty Governors who were expected to authorise the release of prisoners had received no training.

Notwithstanding the apparent concerns, it was also clear to Inspectors that some progress had been made and examples are provided in the following paragraphs.

2.2 In December 2010 the NICTS and the NIPS brought into effect revised procedures with the aim of mitigating the risks associated with mistaken releases. Among the changes were:

- the NICTS providing PECCS copies of signed recognisance (on request) for bail; and
- cases assessed by the NIPS as 'decision of court' would be prioritised for resulting.

2.3 The NIPS have expended circa £177,000 on technical enhancements to the custody functionality of PRISM to improve the handling of Causeway messaging, the primary objective being to reduce the risks of technical issues having an adverse impact on business and hence erroneous releases.

2.4 Further, a number of new processing forms have been devised and delivered. Each has the aim of streamlining procedures and aiding understanding with the objective of mitigating the risks of an erroneous release.

2.5 In addition, the NIPS at the time of the follow-up inspection work in 2011, had

committed to further work which set out to review the committal and discharges processes in order to identify opportunities for improvements. This work was being undertaken by business consultancy services and was seen by Senior Managers in the NIPS as a more fundamental review of the processes impacting on prisoner releases. Arising from their interviews of staff at all levels, Inspectors concluded that the processes to commission this work and the concentration on the projected outcomes arising from it had led to the NIPS shifting its focus away from the operational realities of addressing the immediate risks arising. Inspectors do not suggest that the strategic work commissioned was unnecessary, rather it came too late in the process and took the focus away from the front line operational delivery of immediate improvements.

2.6 Inspectors also sought to conduct validation checks on progress in October 2011 and completed a series of file checks as well as staff interviews. These interviews included senior staff (such as Governors) and staff from the Maghaberry general office. However, the concentration of Inspectors work was focussed in the latter office given the volume of business and the risks associated with that office. This work included a sample review of some 25 discharge/release files. Further outcomes of the file review are provided post. However, based on the findings arising from their work Inspectors concluded at that time, that the risk of erroneous releases remained unacceptably high. In common with the NIPS own internal audit of March 2011, there then remained a series of concerning issues for Inspectors. Principle among these were:

- a continuing lack of confidence amongst staff in their role and the support available to them;
- the absence of training;
- the absence of policy/procedural guides (Know Your Job guides);
- the absence of confidence and training for Governors who were expected to authorise final releases;
- the absence of a clear corporate governance structure across the NIPS estate to address the recommendations and risks; and
- the findings from the file sample review (see post).

File sample

2.7 Inspectors conducted a review of 25 discharge/release files selected randomly from a larger sample of final discharges between 1 July 2011 and 30 September 2011. In summary, the main issues highlighted from this file review were as follows:

- a lack of consistency in file structure and content;
- some prisoners flysheet authorising the release had not been properly completed or signed by the Duty Governor. (This flysheet was introduced as an aide memoir and audit tool for the final discharge of prisoners following the October 2010 report);
- one prisoner was released on 1 September 2011, however a warrant for his arrest had been issued on 28 June 2011. There was nothing immediately apparent on file to suggest what, if anything, had been done to address this;
- one life sentence prisoner had

nothing recorded on his file as to who had authorised his release or when. Staff explained that this might be recorded in his lifer management file, but Inspectors would have expected to see some cross reference material in the general office file;

- in one case discharge had been authorised on the basis of extradition warrants faxed to the NIPS by the Police Service of Northern Ireland (PSNI), but there was no further evidence on file or on PRISM of pre-release checks by the NIPS; and
- in a number of cases the discharge book had not been checked prior to release.

Other findings

2.8 Arising from their fieldwork, including staff interviews and the review of documentation, Inspectors concluded that there were remaining issues of concern in the following main areas:

- there was no clarity as to who was responsible for leading on policy matters affecting the erroneous release of prisoners. Policies were out-of-date and in need of revision;
- one of the main recommendations made in October 2010 was that the reform and implementation of the recommendations was to be project managed. Inspectors found little evidence that this had taken place across the NIPS. This had resulted in a piecemeal approach across the Service with the three main establishments at Maghaberry, Hydebank Wood and Magilligan, essentially doing their own thing;
- at the time of follow-up inspection there was no corporacy to the final release checks across the NIPS, with the Integrated Court Operation System (ICOS) not being available to all establishments and not available to Duty Governors at weekends;
- many of the 2010 recommendations which Inspectors considered capable of being resolved quickly (for example, Know Your Job guides) had not been put in place;
- additional training in many instances and most notably for Duty Governors who were expected to authorise final release had not been delivered; and
- the final authorisation of release by Duty Governors did not take account of sentence calculation as this was considered a specialist function which Governors could not check/did not have the knowledge or training to question. Thus there was no quality assurance check of sentence calculations prior to final discharge.

2.9 The issues of concern were underpinned by many at all levels spoken to by Inspectors. One senior member of staff commented, *"We are developing on the hoof and fire-fighting."* Another commented, *"We're in survival mode."* This was further underscored by many staff who described to Inspectors a lack of confidence and thus the risks of further erroneous releases remained *"high"*. A senior Governor stated, *"The system is failing in a number of ways."* It was particularly unsatisfactory to note that while the NIPS enquiry report of November 2010 commented '*Existing practices highlight several control weaknesses and support the view that there is not a culture in the NIPS of carrying out independent checks or applying adequately robust governance arrangements*' that Inspectors saw the same issues being repeated.

2.10 Arising from their initial fieldwork, Inspectors provided initial feedback to the Director General of the Prison Service. This resulted in additional resources being applied and governance arrangements being put in place to address immediate concerns. For example, a senior Governor was appointed to project manage outstanding work and the issues were included as part of the SEE Programme overseen by the Director General.

External barriers

2.11 During fieldwork connected with this follow-up inspection it was apparent to Inspectors that in a number of areas the NIPS business processes were reliant on a number of external data sources. Staff at all levels referred to these as issues of confidence in the data they were dealing with. The issues can be summarised into a number of distinct areas as discussed in the following paragraphs:

2.12 As highlighted in their first report on this subject, Inspectors acknowledge that part of the complexities surrounding the NIPS processes concern the fact that many of the other criminal justice agencies use case specific data and references, as opposed to those concerning individual persons (nominal's). This means that systems have to be checked for each detainee to ensure that no other case warrants/appointments etc are outstanding. However, one of the main difficulties concerns duplicate nominal's. In other words, persons who are created in the system under different names/name spellings/dates of birth, which are not resolved at source. This can mean for example, that warrants/appointments/alerts in a different name could be missed. The latter can concern data input by any of the criminal justice agencies. Inspectors again heard that pro-active steps were being taken by the PSNI to merge duplicate nominals in the system and did so on behalf of other agencies. The PSNI have a dedicated specialist team working directly on these issues and matters concerning data quality. The merging of historic cases since the Data Sharing Mechanism Phase 1(DSM1) has been completed. However, it was apparent to Inspectors that this was set to be an ongoing issue with, for example, third party cases outside the control of the PSNI, such as those concerning motor taxation, TV licensing etc., leading to longer term issues of data matching in the absence of full information. The existing focus for the PSNI is on current cases and new cases, where Inspectors learned that the numbers of merges are reducing. The average number of merges per month (over the period between September 2011 and February 2012) was 876.

2.13 A further issue concerns the transfer of data from the NICTS to the NIPS (via Causeway). This was stated by staff to have the potential to create additional risks and while that is indeed the case, Inspectors assessed the risks in terms of volume as low. However, Inspectors saw some evidence that the risks, while low, were still extant at the time of their fieldwork. Risks may result from the timeliness of data transfer, however Inspectors learned that the NICTS have a number of standards relevant to this area, including that all bail and custody results are confirmed prior to close of business each day, and secondly that results are confirmed in priority order

beginning with those matters of greatest risk (for example, where custody is concerned). There is also an understanding that the NIPS staff may, as a contingency, request court orders manually (by fax) where necessary. Overall, the issue of timeliness is not a major risk. The greater risk may in fact present from incorrect resulting. In this matter, the NICTS are acutely aware of the need for accuracy and have established a number of quality assurance processes. This includes a second level independent verification of records. While 100% accuracy is the target, it is clear that a very small potential for error still exists. The NICTS have provided data on the number of amendments and deletions completed each month for the six month period from July 2011 to December 2011 (see Table 1 below). This data reveals an error rate of 0.94% for this period or 1,221 corrections after confirmation. The NICTS have indicated that their analysis has confirmed a high proportion of amendments do not relate to issues of bail or custody, and this is due to the management controls in these areas. While CJI are not in a position to confirm this evidence seen by Inspectors it showed that a number of potential erroneous releases were prevented and situations of 'over-hold' were similarly prevented by NIPS staff diligence, albeit that not all such matters result from the NICTS data. Importantly, the NICTS have invested a considerable amount of time and resources in implementing strengthened controls and reporting arrangements on result checking.

2.14 A further matter of concern highlighted to Inspectors during the course of fieldwork was the use and understanding of language across areas of the criminal justice system. One example, highlighted in Inspectors file reviews, was when the messaging from the NICTS indicated a charge as 'withdrawn'. To those untrained or unfamiliar with the courts this would ordinarily mean that the case has been discontinued. However, it was apparent that this can mean a number of things, including that the charge has been withdrawn and substituted with another. Since the last inspection report a number of such issues have been addressed and, for example, the NICTS have introduced additional court results such as 'Withdrawn Crown Court Committal'.

Table 1

Month	Results Confirmed	Amendments	Deletions
July 2011	18,131	95	88
August 2011	21,354	92	61
September 2011	24,994	133	137
October 2011	22,840	107	134
November 2011	23,286	101	122
December 2011	19,449	84	67
Total	**130,054**	**612**	**609**

2.15 In addition to the steps taken surrounding data quality Inspectors learned that a senior member of Courts Service staff had been seconded to the NIPS for a period of six weeks and worked in all NIPS general offices. Staff from the NIPS general office were also provided with familiarisation training by NICTS staff, and Inspectors heard positive comment that this had aided understanding. In addition, Inspectors are aware that the NIPS and the NICTS are working collaboratively on a new service level agreement, and Inspectors suggest that areas of risk are incorporated and addressed in that agreement, including common language and issues of resulting. The issue of accuracy in resulting court orders is a matter which CJI intend to return to in the future with a full inspection. Otherwise, Inspectors advocate that the NIPS keep the issue under review and immediately flag any matters of concern regarding incorrect resulting with the NICTS.

2.16 In all these areas while there clearly are some residual risks, it is worthy of bearing in mind that such data errors have resulted in only one of the erroneous releases since September 2010. It is equally clear that controls are in place to contain the risks. That of course does not mean that the risks can be entirely eliminated, rather that they are being managed. In addition, Inspectors view the risks associated with data reliability as matters which should be addressed by the NIPS with relevant partner agencies on an ongoing basis in order that trends can be monitored and further remedial actions, where necessary, instituted. Such a continual process of information sharing and learning (as opposed to the apportionment of any blame) is regarded as a healthy way to address such problems.

Additional progress

2.17 Inspectors completed a further series of validation checks and meetings in January and February 2012, among these being visits to the general offices in both Maghaberry and Hydebank Wood, as well as visiting PECCS in Downpatrick Court. Inspectors also sought and received further updates and evidence of compliance from the NIPS in January and February 2012. Inspectors are content to report that many of the underlying immediate operational issues which needed to be addressed have now received further immediate attention. While some issues remain to be resolved across the NIPS estate, it was clear to Inspectors during fieldwork in January/February 2012 that further incremental progress was being made. In addition, it was significant to note that front line staff reported a greater degree of confidence that changes were beginning to be realised in terms of increasing confidence. Arising from the work conducted by Inspectors, it is possible to conclude that of the 25 NIPS recommendations, 14 (56%) can be said to be met in full. A further 10 (40%) can be said to partly completed, and one (4%) as discharged (no longer relevant). Inspectors detailed assessment of progress and comment where necessary (by exception), is included at Appendix 1.

2.18 Of the outstanding recommendations yet to be completed, Inspectors are now satisfied that the governance arrangements, the willingness to address and focus on these matters, means that the risks of further erroneous releases

are capable of reduction. However, Inspectors should also make it clear that the complexities of sentence calculation and the reliance by the NIPS on data supplied by other parties, means that the risk of an erroneous release cannot ever be said to be eradicated entirely. It is also clear from the research of Inspectors that the rate of erroneous releases is only marginally higher than in the comparable jurisdiction of England and Wales. Additionally, it was clear to CJI during fieldwork in February 2012, that NIPS systems were regularly detecting and addressing potential erroneous releases and/or 'over-holds'.

2.19 Despite the positive progress however, it was apparent to Inspectors that a clear operational focus and the maintenance of quality assurance processes are required to minimise the risks of erroneous releases. Inspectors would also highlight that the NIPS must maintain a healthy balance between ensuring the risks of erroneous releases and over-holding are achieved. The latter can be achieved through a combination of good preparation, confidence in systems and liaison with stakeholders.

Conclusions

2.20 While some encouraging progress has been made, and plans for further change are well under-way, Inspectors remain disappointed overall at the pace of progress between the publication of the first inspection report in November 2010, and this follow-up fieldwork. However, the planned further work and projects underway (including external consultancy work), if appropriately focussed and managed, appear to have the capacity to further mitigate the risks associated with mistaken releases. Inspectors fieldwork has also now confirmed that many of the underlying operational issues are being actively addressed, even if not fully executed. Thus, there clearly remains some way to go before the full realisation of a proficient and assured system.

2.21 The NIPS now need to ensure that this issue remains as an organisational priority overseen directly by the Director General and also, consequently, as an organisational risk with appropriate control measures. In this way Inspectors express the hope that this concentration and visibility will combine to ensure that mistaken releases continue to be given fitting visibility and attention.

Section 2

Appendix

Appendix 1: Table of Prison Service recommendations and CJI assessment of compliance

Recommendation Number:	Recommendation:	Status: Completed / Partly Completed / Discharged
1	• The remedial action(s) set out in paragraph 5.7 should be applied, where relevant, to each establishment and regularly reviewed to ensure that they remain apposite and sustainable.	Partly Completed - there is no evidence that the remedial actions have been implemented across all NIPS establishments. • Some procedures manuals remain in draft form. • ICOS remains unavailable to some staff, particularly at weekends. • Risks remain regarding manual warrants not received via Causeway.
2	• The staffing shortages in Maghaberry general office should be addressed immediately.	Completed. Inspectors note while some additional staff have been put in place, it remains the case that not all existing vacancies are filled. This is regarded as part of the normal human resourcing issues in any large organisation.
3	• The working environment in Maghaberry general office should be improved and should include 'quiet' room facilities for sentence calculation and final checks.	Completed.
4	• A comprehensive set of 'Know Your Job' guides, linked to suitable training, should be provided for general office staff, Duty Release Managers and video-link staff in all establishments.	Partly Completed - while job descriptions and standard operating procedures have been delivered to Maghaberry in draft form, not all establishments are using these. Until these guides and standard operating procedures manuals are fully developed training has also been placed in abeyance.
5	• General office staff should be 'clustered' in groups based on function and workflow. Staff should change group periodically to share and develop skills.	Completed.

Recommendation Number:	Recommendation:	Status: Completed / Partly Completed / Discharged
6	• A succession plan should be drawn up for all general office staff to ensure business continuity.	Partly Completed. Some succession planning at more senior levels has been undertaken with a Governor placed in custody/reception and mentoring arrangements. The NIPS report that succession planning for administrative staff is causing some difficulty. There are plans to fully incorporate this recommendation alongside the longer term structural review. Inspectors recognise that this will be an ongoing process and part of typical human resource planning process.
7	• A means of encouraging staff retention in general offices should be considered, for example higher rate environmental allowance for general service grades.	Completed. The NIPS did give consideration to this matter and submitted a business case to the Department of Finance and Personnel for additional environmental payments to address retention. However, this was turned down. Inspectors now consider that the NIPS should evaluate more broad working arrangements and practices in these offices with a view to encouraging staff retention, rather than focus solely on financial reward. This may include dealing with negative perceptions of the risks to individual administrative staff and the working environment and providing appropriate training or other support.
8	• The Governor in charge of the general office in Maghaberry should not be involved in other operational duties, for example Duty Governor or adjudications.	Completed.
9	• The discipline staff assigned to the general office should be placed on domestic shift to maximise their availability.	Discharged - while staff were not placed on a domestic shift, additional staff have been allocated to ensure continuity and availability. To that extent the issue of concern has been addressed.
10	• All staff involved in discharge checks must be trained in the process and in use of live screens to facilitate pre-discharge checks. Until the training is complete adequate out-of-hours support arrangements must be in place.	Partly Completed - full training has not been provided but an IT solution has been. This requires additional ICOS licences. However, Duty Governors have been provided with additional awareness training.

Recommendation Number:	Recommendation:	Status: Completed / Partly Completed / Discharged
11	• General office staff should receive familiarisation training in the work of the NICTS to develop a common understanding of business needs. The staff who carry out management checks in the general office should be provided with access to ICOS.	Partly Completed - familiarisation training has been delivered. However staff access to ICOS is limited. Additional licences for the use of ICOS were being pursued at the time of inspection and Inspectors understand that 10 additional licences have been provided by the NICTS.
12	• The structure of the inmate file should be revised to align the details with the records held on PRISM.	Partly Completed. A working group has been established to look at this issue and a prototype is being trialled. There remain some issues to be addressed before this can be dealt with across the NIPS.
13	• A re-assessment of the duties of the general office in Maghaberry should be carried out to ensure that the focus of the branch is on custody, release and sentence calculation as already happens in Hydebank Wood.	Completed.
14	• The PECCS Governor must ensure that there is a reliable and robust means of communicating information on prisoners who are 'Not For Release' to allow timely access of this information to court-based staff, to reduce duplication and the risk of a transcription error. The current process of the van escorting officer passing on the information should not be relied on in isolation.	Completed.
15	• Written guidance should be issued to PECCS on the process to be followed in order that final checks can be made with general offices to ensure that there are no other matters requiring a prisoner to be held in custody. Such checks need to be expedited to ensure that the release of those individuals who should not otherwise be held is not delayed unnecessarily. This guidance will need to be communicated to the Courts Service, the Judiciary and legal profession.	Completed.

Recommendation Number:	Recommendation:	Status: Completed / Partly Completed / Discharged
16	• The Senior Prison Custody Officer / Prison Custody Officer in charge of the court on taking up duty must check that early notification of Not For Release's has been received.	Completed.
17	• The Senior Prison Custody Officer / Prison Custody Officer in charge of the court should brief Dock Officers on Not For Release prisoners. Where an early oral briefing is not possible the Senior Prison Custody Officer must share the information with Dock Officers as soon as it is available. Dock Officers must also check to ensure that they have a clear unambiguous direction on those prisoners Not For Release and that all 'custody production' prisoners will in any case be taken down to the cell area before release to enable final checks to be done.	Completed.
18	• The warrant summary screen on PRISM should include a facility to take the user quickly through to all system alerts for an individual inmate. The system needs to include an audit trail of alerts and a means of confirming that they have been actioned.	Completed.
19	• The information on the warrant summary screen should be sorted so that the details for each case appear chronologically on the screen.	Completed.
20	• The process to edit and authorise warrants on PRISM should be changed to enable the check and authorisation stages to be recorded separately. These tasks must be completed by a different member of staff to ensure segregation of duties is achieved.	Completed.

Recommendation Number:	Recommendation:	Status: Completed / Partly Completed / Discharged
21	• PRISM should be modified to prohibit users from discharging inmates until all validation checks have been carried out and authorised on the system. Any exceptions authorised by the user should be recorded and printed on the discharge documentation.	Partly Completed. The use of PRISM validation checks is currently being trialled by Hydebank Wood. Full evaluation and roll-out had not been completed at the time of inspection. In the meantime, Maghaberry continues to use a paper-based system of validation checks.
22	• Additional controls should be included on PRISM to prevent users from discharging inmates using unscheduled appointments.	Partly Completed. At the time of inspection fieldwork in early February 2012 electronic solutions had not been delivered, but were planned for delivery later in the same month. Staff reported that unscheduled appointments were not now 'routinely' used.
23	• There should be a facility to provide a discharge report on PRISM that highlights the actions that need to be taken prior to discharge with particular reference to public protection.	Partly Completed. This issue can be linked to 21 above. The use of PRISM validation checks is currently being trialled by Hydebank Wood. Full evaluation and roll-out have not been completed. In the meantime, Maghaberry continues to use a paper-based system of validation checks.
24	• The discharge process should be reviewed in its entirety in conjunction with other agencies and Causeway officials to determine whether any proposed business changes can be incorporated into the integrated system. The review should not be limited to the issues raised in this enquiry and should also examine how individual agencies' competing business needs are met.	Partly Completed. Significant work is underway in this area with, for example, independent consultants employed as a first step. Inspectors view this work as important but of a longer term nature before full compliance can be said to be reached.
25	• The changes proposed by the enquiry should be managed as a change programme by a Senior Manager with experience in systems controls and governance.	Completed.

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