الأمانة العامة
للتظلمات
OMBUDSMAN
Ministry of Interior وزارة الداخلية

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Annual Report

2013 / 2014

مملكة البحرين
Kingdom of Bahrain

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Bahrain Independent Ombudsman

First Annual Report
2013 / 2014

Foreword by the Ombudsman

Nawaf M. Al Moawda

It is with great pleasure that I bring you this report of the work of the Office of the Independent Ombudsman from the time it became operational in July 2013 to the end of April 2014.

The Office of the Independent Ombudsman was set up by Royal Decree 27 as part of the strategy for building a better future in Bahrain and was launched in the Kingdom of Bahrain on Tuesday 2 July 2013. The Office, which considers complaints against employees of the Ministry of the Interior, is the first of its kind in the Gulf region. It is also the first of its kind in the Middle East. The Office was launched in record time compared with similar offices opened in other countries.

"The Office of the Independent Ombudsman became operational in July 2013. The Office, which considers complaints against employees of the Ministry of the Interior, is the first of its kind in the Gulf region."

The establishment of the Ombudsman of the Ministry of the Interior was part of the wider response drawn up by the Kingdom of Bahrain to achieve political and institutional reform and promote human rights. It was also

within the spirit of the National Action Charter and the Constitution of the Kingdom of Bahrain and was part of the reforms of His Majesty King Hamad bin Isa Al Khalifa.

The inception responded to the Bahrain Independent Commission of Inquiry (BICI) Recommendations 1717 and 1722(d), aimed at ensuring that employees of the Ministry of the Interior deal with the public in a manner that is appropriate and respectful of human rights. The Office also has specific responsibilities in relation to the treatment of prisoners and detainees within the purview of the terms of reference approved in Decree 27 issued on 28 February 2012 and amended by Decree 35 issued on 28 May 2013.

"Five basic principles underpin the Ombudsman Office work: independence; credibility; impartiality; accountability and transparency."

Reflecting its commitment to the delivery of a fair and just service, the Ombudsman Office selected an emblem with five parts symbolizing the five basic principles underpinning its work: independence; credibility; impartiality; accountability and transparency. These important principles emanate from the arrangements and safeguards stipulated in the establishment decree and are protected by the financial and administrative independence of the Ombudsman.

The Ombudsman Office exercises its functions and duties in two specific areas: Firstly, the Office receives complaints from citizens in the community or in places of detention, expatriates (or even

visitors) or their representatives. Complaints alleging misconduct or criminal acts by civilian or police personnel of the Ministry of the Interior, that may warrant criminal or disciplinary proceedings, may also be made by witnesses or civil society organisations.

Secondly, the Ombudsman Office staff visit prisons, places of juvenile care and places of custody and detention, to verify the appropriate application of legal procedures and to ensure that prisoners and detainees are not subject to torture or cruel, inhuman or degrading treatment. The Ombudsman is also immediately notified of all deaths that occur in prison, places of juvenile care and places of custody and detention in order that an investigation into the circumstances of the death can commence.

Whilst operating independently, the Ombudsman Office works cooperatively with other relevant authorities, such as the Public Prosecutor, the Special Investigation Unit, the disciplinary courts within the Interior Ministry, the disciplinary committees of civil servants and other relevant agencies and departments. The Ombudsman receives complaints in a variety of ways, including by complainants visiting the Ombudsman Office, by e-mail and by post. Complaints received are reviewed to confirm eligibility.

If, during the course of an investigation, if it is determined that disciplinary proceedings are merited, the Ombudsman Office notifies the relevant department in the Ministry of the Interior. Similarly, where the evidence examined suggests that a criminal act may have been committed; cases are referred to the Public Prosecution or the Special Investigations Unit. Where a case is referred,

"Between the beginning of July 2013 and the end of April 2014, the Ombudsman Office received 242 complaints from complainants in the community and places of detention."

the Ombudsman will forward all of the evidence secured during the investigation to the relevant authority. The Ombudsman Office will then monitor the progress and outcome of the investigation and keep the complainant informed.

The complaint investigations carried out over the last ten months, covered a wide range of concerns, allegations of misconduct and alleged violations, as detailed in Section One. Many cases were, following investigation, referred to other authorities and many other recommendations for action were issued to the establishment(s) where the complaint(s) originated. Other cases were not upheld.

Between the beginning of July 2013 and the end of April 2014, the Ombudsman Office received 242 complaints from complainants in the community and places of detention. 39 of these are still under investigation by the Ombudsman. Of those completed 29 were referred to the Special Investigations Unit, 15 to the Security Prosecution and one to the Public Prosecution. Of the 29 cases thst were referred to the SIU, two have been forwarded to the Criminal Court. Of the 15 that went to the Security Prosecution investigations are still ongoing in eight cases and four have either been resolved or not upheld. Three cases went to the Security Courts and one of these led to a conviction (of six months imprisonment and fines), one resulted in disciplinary action and one is still in the courts.

49 complaints resulted in recommendations for action being made to the establishment(s) where the complaint(s) originated. 109 complaints were either not eligible for investigation by the Ombudsman (because they did not concern the Ministry of the Interior), were resolved or were not upheld. 12 members of the Ministry of the Interior were referred to the Criminal Courts, following criminal investigations resulting from Ombudsman referrals. The Ombudsman is monitoring the progress of all of these cases.

The Ombudsman undertakes two types of visit to prisons and places of detention: field visits that are announced and field visits that are not announced. In both instances, clearly laid down procedures are followed and an assessment is carried out using benchmark standards and criteria, prepared in cooperation with Her Majesty's Inspectorate of Prisons (HMIP.) The considerable experience of HMIP was very beneficial in ensuring the development of professional, international standards and these were announced to the public at a press conference held in September 2013.

"The ombudsman Office issued the first prison and detention facility visit/standards in the GCC."

Between 3 and 5 September 2013, a team from the Ombudsman Office carried out a three day inspection of Jau Prison. In accordance with the benchmark standards, the visit considered the areas of: humane conditions and treatment; prisoner rights

and guarantees and prison healthcare provision. It is to note that, in April 2014, the Supreme Judicial Council endorsed these standards in a move to standardise the criteria applied in prisons for both the Judiciary and the Ombudsman.

In September 2013, the Ombudsman Office announced the findings of the Jau Prison inspection. The resulting Inspection Report is the first of its kind in the Region and indicates the progress made in the Kingdom of Bahrain to promote the concept of treating prisoners and detainees in a manner that is humane and respectful of human rights. The report noted evidence of good practice, but also described significant concerns in connection with serious overcrowding, under staffing, inadequate health care provision and insufficient education and purposeful activity provision. It included 18 general and healthcare-related recommendations for action that were accepted by the Ministry of the Interior.

In November, the Ombudsman recommendation calling for the separation of detainees aged between 15 and 18 from adult inmates and the allocation of special wards and cells for them, was implemented.

As stated, the Ombudsman Office investigates complaints from detainees or prisoners held in reform and rehabilitation centers. These may be received from individuals or through civil society organisations. The Ombudsman Office investigates these complaints in accordance with specified investigative procedures and standards to ensure the principles of independence, accountability and transparency. 107 complaints were received from detainees and prisoners between the beginning of July 2013 and the end of April 2014

Ombudsman investigations relating to prisoners and detainees have given rise to a number of issues of concern which need to be addressed urgently. Many of these relate to the quality of healthcare received by prisoners and detainees and include: the arrangements for access and transport to the prison / detention centre clinic; the time required to transfer a prisoner or detainee to a hospital in cases where this is required; the arrangements for dispensing prescribed medications and administering treatments at the required time and the maintenance of medical equipment at the clinic facility.

"The increase in the number of complaints, suggests growing confidence in the service provided by the Ombudsman.."

The Ombudsman is also pushing for the strengthening of the arrangements for safety and risk management in all places of detention. In this context, and based on other Ombudsman findings in prisons and custody centres, the Ombudsman has recommended setting up surveillance cameras in all buildings, corridors and wards, in line with international best practice standards.

Section One of this report details the complaints received by the Ombudsman Office over time. The increase in the number of complaints, suggests growing confidence in the service provided by the Ombudsman. This, in turn, emphasises the imperative for

the Ombudsman Office to continuously develop the way in which it delivers its responsibilities. Current priorities include the further development of arrangements for communicating with complainants to inform them of the progress of complaint investigations and the achievement of greater accessibility to the services of the Ombudsman. In this context, complaint boxes will, in the near future, be placed in all police districts, police stations, correctional and rehabilitation centres and other agencies of the Ministry of the Interior. The boxes will be locked to ensure privacy and confidentiality and will be emptied regularly by members of the Ombudsman Office staff.

An additional very important responsibility of the Ombudsman Office is the investigation of deaths in detention or the death of any detainee transferred to hospital. The Ombudsman investigation into the death considers the cause of death and the adequacy of the care provided to the deceased inmate. It ensures also that their treatment was appropriate and human rights compliant. Losing a family member is always difficult, but losing a loved one in a place of detention can be particularly difficult for families. The Ombudsman Office is, therefore, currently working on the development of procedures for dealing with the families of those who die in custody.

"A very important responsibility of the Ombudsman Office is the investigation of deaths in detention or the death of any detainee transferred to hospital."

The Ombudsman is also working to further develop the arrangements for exchanging information, evidence and investigation findings with other competent administrative, medical or judicial authorities.

One of the most significant challenges faced by the Ombudsman, particularly during the period of inception, was to recruit and train investigators and support staff. This was particularly difficult because the work of the Ombudsman was new to Bahrain and there was no civilian agency with experience of investigating complaints, or visiting prisons and detention centers. The implementation of high quality training and development programmes was therefore given a high priorty. The Ombudsman Office personnel, who include male and female employees with legal backgrounds, including investigators and inspectors, attended training provided by experts from Bahrain and abroad. This included attendance at practical training courses to develop knowledge and experience in the Interior Ministry Directorate of Disciplinary Courts, the criminal courts, the Public Prosecution and the Department of Correction and Rehabilitation.

In the same context, a professional Operations and Investigations Manual has recently been prepared and implemented for the Ombudsman staff. The procedures described in the Manual, which details best practice investigation standards, has been prepared with the participation of international experts renowned for their experience and competence. It is intended that the practice and procedures detailed in the Manual will overcome some of the difficulties and delays, relating to the collection of evidence from various sources and the interviewing of witnesses, encountered by the Office.

In light of the fact that the Ombudsman Office is new to everyone, the Ombudsman has been very keen to focus on the challenge of community outreach. In support of this, the Ombudsman Office launched, in conjunction with its own official launch at the beginning of July 2013, a media campaign to raise the general public awareness of the responsibilities, functions and services of the Ombudsman. The campaign, in several languages, utilised all forms of media, from the press to radio and television and engaged local, Arab and international media organisations.

The Ombudsman Office has been keen also to develop positive communications with Members of Parliament. To this end, a seminar was held at the Shura (Consultative) Council in December to explain the Ombudsman Office responsibilities and powers. The seminar was attended by several Members of the bicameral Parliament (Council of Representatives and Shura Council).

In July 2013, Ombudsman staff visited a number of foreign embassies in Bahrain. The aim of these visits was to ensure effective communication with the representatives of foreign expatriates living in Bahrain and to familiarise them with the role of the Ombudsman and the legal rights of these expatriate communities, when dealing with employees of the Ministry of the Interior.

The engagement by the Ombudsman both nationally and internationally has resulted in important outcomes and achievements. Most notably, the Bahrain Ombudsman became a member of the International Ombudsman Institute (IOI), a well-respected international institution with a membership of more than 140 ombudsmen worldwide. This recognition followed a review by the IOI Executive Committee in September 2013 which confirmed that international, independent complaint investigation standards and conditions were being delivered in Bahrain.

The Ombudsman Office also participated in the establishment of the first Association of Ombudsmen in the Islamic countries, attending the first conference of the member countries of the Organisation of the Islamic Cooperation. This was held in the Republic of Pakistan on 28–29 April 2014.

"The Bahrain Ombudsman became a member of the International Ombudsman Institute (IOI), a well-respected institution with a membership of more than 140 ombudsmen worldwide."

In support of the development of bilateral cooperation, the Ombudsman signed a Memorandum of Understanding with the Special Investigation Unit in July 2013, to ensure professional cooperation between the two organisations. The Ombudsman also signed a Memorandum of Understanding with the National Institution for Human Rights in December 2013, agreeing a framework to regulate coordination and cooperation.

As part of its external outreach, the Ombudsmen Office has had very informative and positive contacts with numerous institutions and agencies abroad, including working visits to England, Northern Ireland, France and the United States of America. Regular contact is maintained with international Ombudsman and organisations and institutions working in the field of human rights, as well as with the embassies based in the Kingdom of Bahrain.

As this first Annual Report (2013-2014) is published the Ombudsman, in line with the commitment to engagement and transparency, wants to inform the general public and all interested stakeholders about significant achievements to date, but also challenges moving forward, bearing in mind the expectations of, and hopes for, the Ombudsman Office.

"Significant progress has been made. The Ombudsman is, however, well aware that there is more that needs to be achieved and that continuous development moving forward will be essential."

The Office has made significant progress since its inception, particularly in: implementing the required administrative and professional operational framework; developing methodologies and standards for investigating complaints; making visits to rehabilitation and detention centres and ensuring stakeholder engagement.

The Ombudsman is, however, well aware that there is more that needs to be achieved and that continuous development moving forward will be essential to successful delivery. This development will be informed by practical experience, developing knowledge and understanding, detailed analysis of management information and by the findings and conclusions of complaint investigations and inspections. These factors will inform our future vision and service planning process.

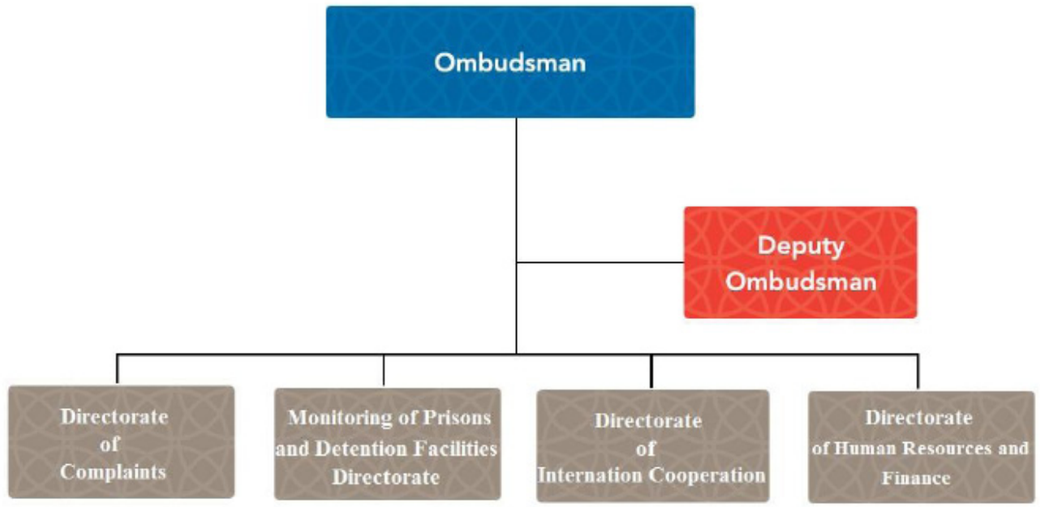
In conclusion, I wish to express my profound gratitude and appreciation to all the ministries, institutions and agencies that have cooperated with the Ombudsman Office and provided invaluable assistance, over our first ten months. These include: the Ministry of the Interior; the Ministry of Justice, Islamic Affairs and Endowments; the Ministry of Foreign Affairs; the Ministry of Health; the Ministry of Human Rights Affairs; the Information Affairs Authority; the Supreme Judicial Council; the Public Prosecutor's Office; the Special Investigation Unit; The Ombudsman of the National Security Agency (NSI); the Legislation and Legal Opinion Commission and the National Health Regulatory Authority.

I must also recognise with gratitude, the efforts and support of the National Institution for Human Rights, the Commission for the Rights of Prisoners and Detainees, Her Majesty's Inspectorate of Prisons in the United Kingdom, Northern Ireland Cooperation Overseas, the embassies and others who hosted diplomatic missions and the other overseas organisations that are in permanent contact with the Ombudsman Office.

Finally, I wish to thank the Deputy Ombudsman; the directors and advisors; the heads of department and all of the members of staff who work in the Office of the Ombudsman, for their dedication and considerable efforts over the last ten months. I am confident that the competence, integrity and professionalism of the Ombudsman Team and their commitment to upholding the integrity and values upon which the office was established, will ensure that we do justice to the high hopes for the Office.

I look forward to building on the progress made in the year ahead.

Ombudsman Office Organisation Structure



Section One

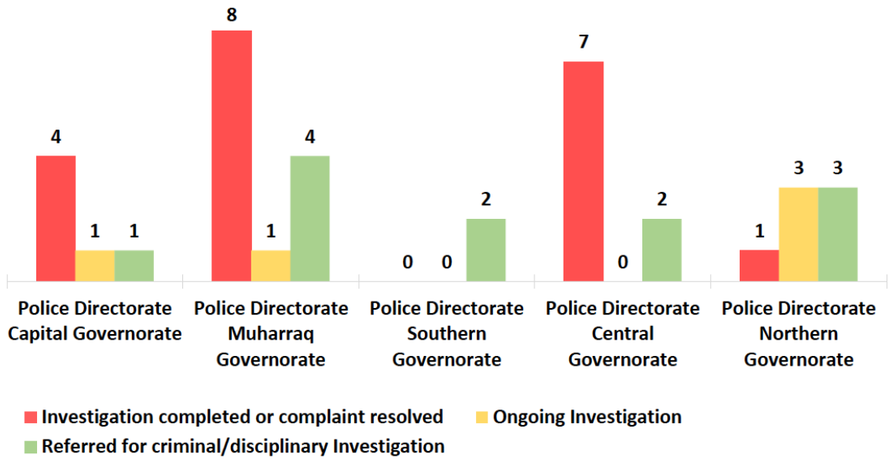
Complaint Statistics

This section details performance statistics related to the work undertaken by the Ombudsman Office during the period June 2013 to April 2014. The information presented describes the number of complaints received; how the complaints were submitted; where they originated from and the action taken following investigation.

Actions taken in connection with complaints investigated by the Ombudsman Office

Institution	No.
Recommendation for action related to Ombudsman Standards for Prisons and Places of Detention	49
Referred to criminal and disciplinary investigation committees	45
Investigation still on going	39
Complaint resolved or not upheld	109
Total	242

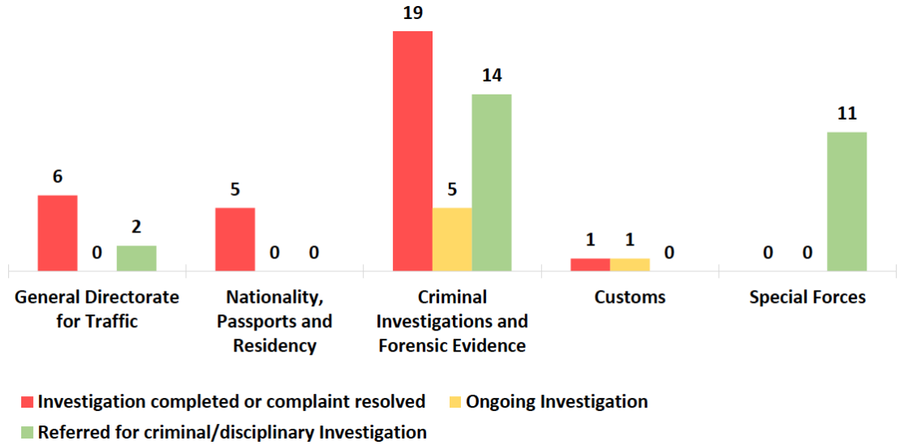
Complaints Against Directorates / Institutions



Directorate	Investigation completed or complaint *resolved	Ongoing Investigation	Referred for criminal/disciplinary Investigation	Total
Police Directorate Capital Governorate	4	1	1	6
Police Directorate Muharraq Governorate	8	1	4	13
Police Directorate Southern Governorate	0	0	2	2
Police Directorate Central Governorate	7	0	2	9
Police Directorate Northern Governorate	1	3	3	7
Total	20	5	12	37

* This includes complaints not upheld as well as those resulting in recommendations for action /change

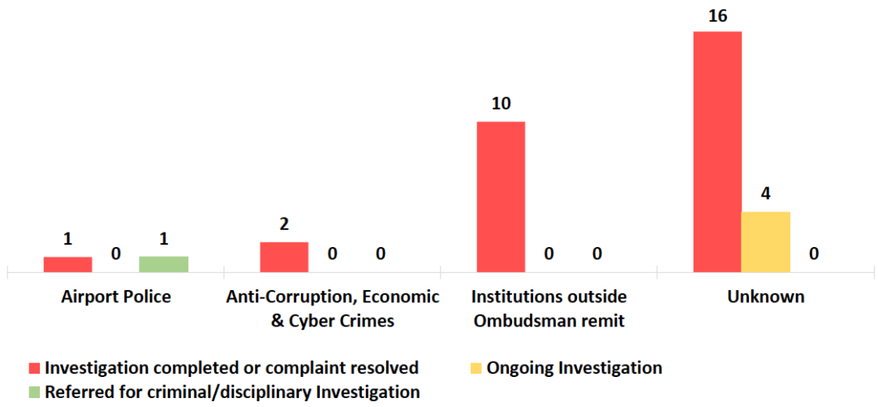
Complaints Against Directorates / Institutions



Institution	Investigation completed or complaint *resolved	Ongoing Investigation	Referred forcriminal/disciplinary Investigation	Total
General Directorate for Traffic	6	0	2	8
Nationality, Passports and Residency	5	0	0	5
Criminal Investigations and Forensic Evidence	19	5	14	38
Customs	1	1	0	2
Special Forces	0	0	11	11
Total	31	6	27	64

* This includes complaints not upheld as well as those resulting in recommendations for action /change

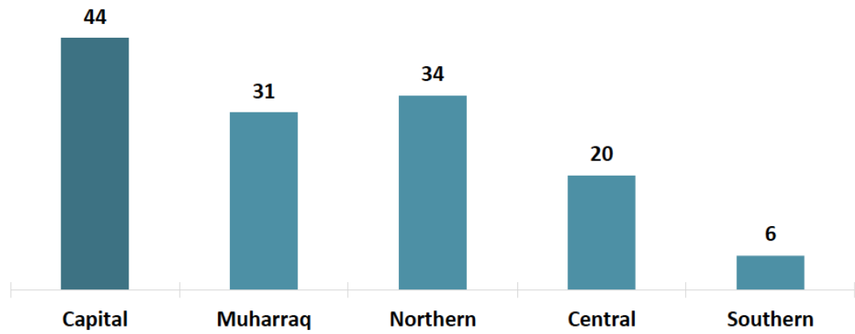
Complaints Against Directorates / Institutions



Institution	Investigation completed or complaint *resolved	Ongoing Investigation	Referred for criminal/disciplinary Investigation	Total
Airport Police	1	0	1	2
Anti-Corruption, Economic & Cyber Crimes	2	0	0	2
Institutions outside Ombudsman remit	10	0	0	10
Unknown	16	4	0	20
Total	29	4	1	34

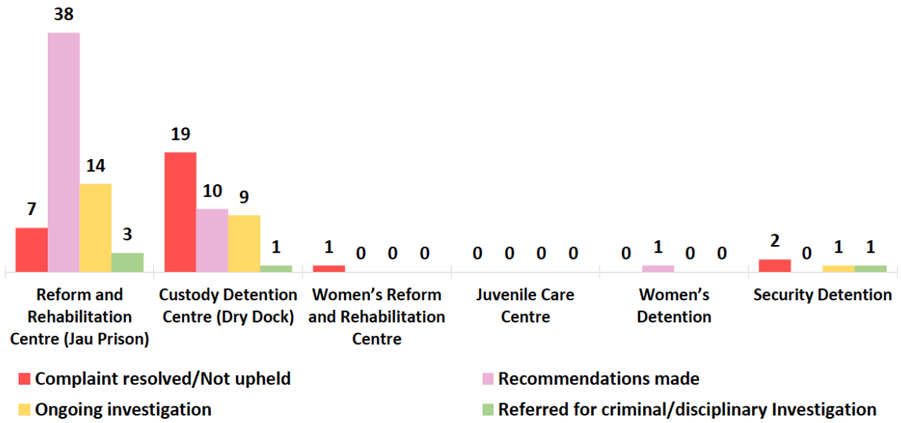
* This includes complaints not upheld as well as these resulting in recommendations for action/change

Locations where complaints originated



Governorate	Number
Capital	44
Muharraq	31
Northern	34
Central	20
Southern	6
Total	135

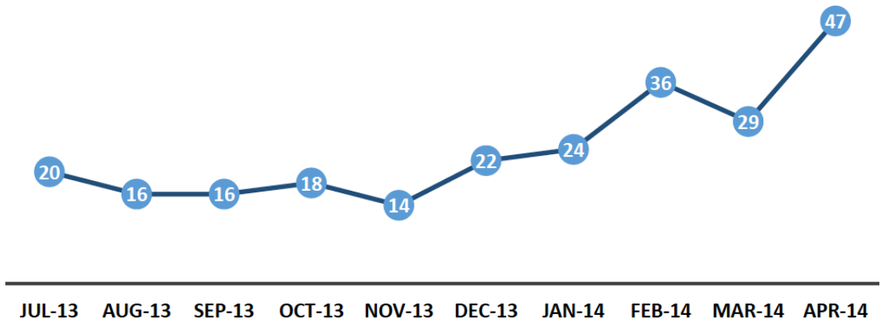
Complaints Originating from Detention & Rehabilitation Centres



Institution	Complaint resolved/ Not up-held	Recom-menda-tions made	Ongoing in-vestigation	Referred for crimi-nal/dis-ciplinary investiga-tion	Total
Reform and Rehabili-tation Centre (Jau Prison)	7	38	14	3	62
Custody Detention Centre (Dry Dock)	19	10	9	1	39
Women's Reform and Rehabilitation Centre	1	0	0	0	1
Juvenile Care Centre	0	0	0	0	0
Women's Detention	0	1	0	0	1
Security Detention	2	0	1	1	4
Total	29	49	24	5	107

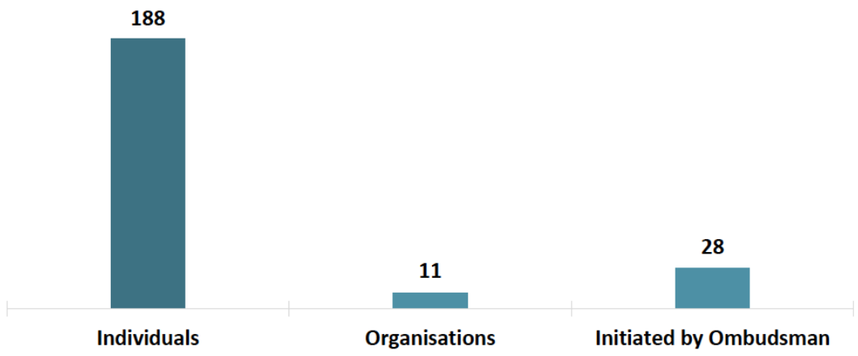
* Includes complaints not eligible for investigation by the Ombudsman of Ministry of Interior

Complaints figures received each month



Months	Number
July 2013	20
August 2013	16
September 2013	16
October 2013	18
November 2013	14
December 2013	22
January 2014	24
February 2014	36
March 2014	29
April 2014	47
Total	242

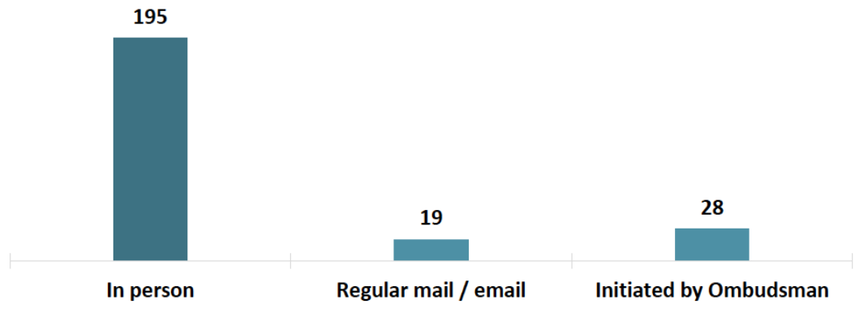
Origin of complaints



Origin	Number
Individuals	188
Organisations	11
Initiated by Ombudsman	28
Total	*227

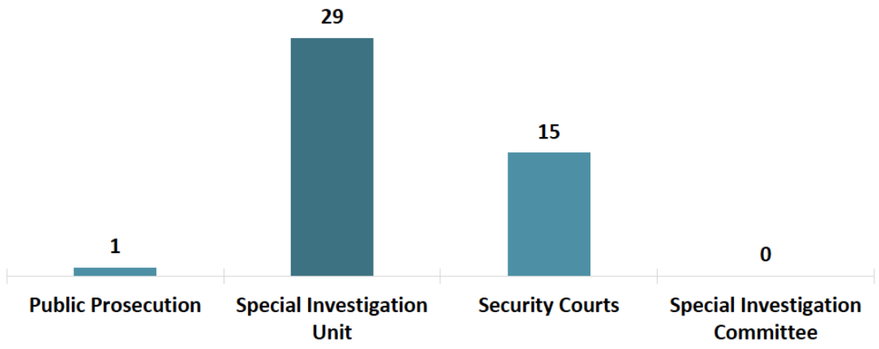
* A small number of individuals submitted more than one complaint resulting in a total of 242 complaints received

Method of complaint submission



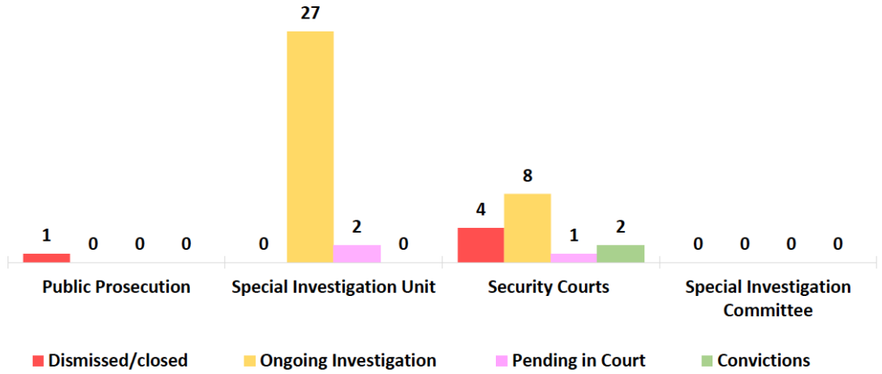
Method of submissions	Number
In person	195
Regular mail / email	19
Initiated by Ombudsman	28
Total	242

Organisations to which Ombudsman complaints referred for criminal/disciplinary Investigation



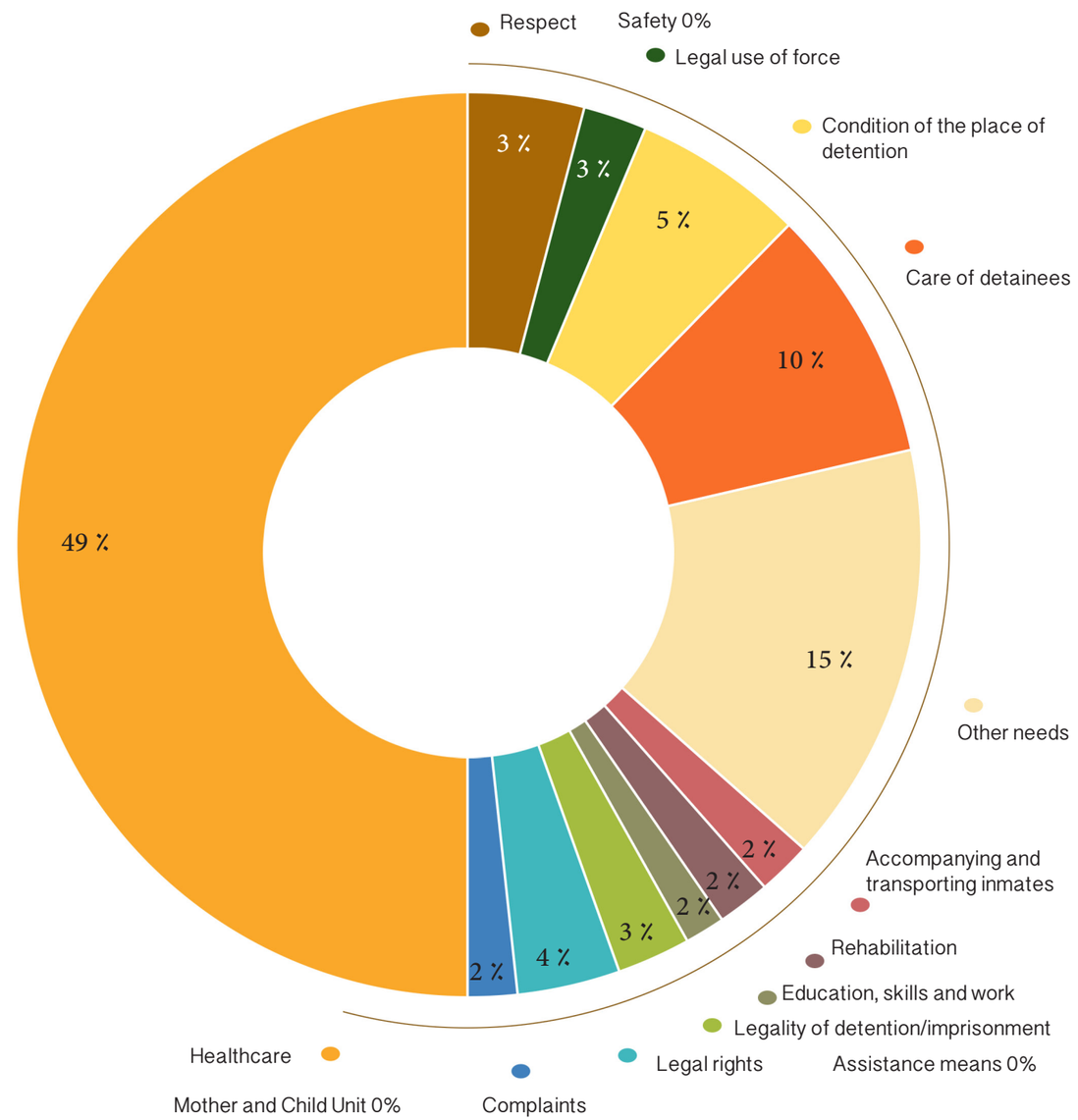
Institution	Total
Public Prosecution	1
Special Investigation Unit	29
Security Courts	15
Investigation Committes for Civil Employees	0
Total	45

Referred case follow up



Institution	Dismissed/ closed	Ongoing Investi-gation	Pending in Court	Convictions	Total
Public Pros-ecution	1	0	0	0	1
Special In-vestigation Unit	0	27	2	0	29
Security Courts	4	8	1	2	15
Special In-vestigation Committee	0	0	0	0	0
Total	5	35	3	2	45

Complaints arising in prisons and places of detention



Subject matter of complaints arising in prisons and places of detention centres (classified in accordance with ombudsman prison and detention standards)

classified	Number
Respect	4
Safety	0
Legal use of force	3
Condition of the place of detention	6
Care of detainees	11
Other needs (Exercise, Reading, Visits, Communication etc.)	17
Accompanying and transporting inmates	2
Rehabilitation	2
Education, skills and work	2
Legality of detention/imprisonment	3
Assistance means	0
Legal rights	4
Complaints	2
Mother and Child Unit	0
Healthcare	55
Total	*111

* Four complaints have been allocated to two categories reflecting the content of the complaint

Section Two

Examples of Ombudsman Complaint Investigations

Example One

Ombudsman Office Support for Inmate Education

The Ombudsman has emphasised the need for those in detention to have adequate opportunities for education. As government school students were sitting their mid-year exams, a team of investigators from the Ombudsman Office, keen on following up the educational progress of some detainees at the reform, rehabilitation and custody centres, visited those who were taking their exams at the centres in Jau and Dry Dock.

The purpose was to monitor how effective, supportive and encouraging the arrangements for inmate education related examinations are, for detainees and prisoners.

The team of inspectors concluded that adequate examination arrangements were in place for students keen on pursuing their studies and that the management in both centres, made efforts to ensure satisfactory facilities and conditions for the students sitting exams.

Example Two

Distribution of Winter Clothing

The Ombudsman Office was contacted by the National Institution for Human Rights in connection with claims published by some newspapers that detainees at Dry Dock Detention Centre were not receiving winter clothes sent to them by their families.

An Ombudsman Team visited Dry Dock and met the officers tasked with handing over clothes to detainees. They also asked the staff of the department about the procedures to be followed when delivering winter clothes.

The investigators established that all clothes provided by families are passed on to the officers responsible for distributing the garments, who then inspect them to ensure that they do not contain any banned substance or items that could be classified as a threat to security. The clothes should then be handed over to the inmates within 24 hours.

A random sample of inmates noted in the "clothing delivered" records as having had clothing brought in by their families, were asked by inspectors about their personal experience of the procedure. All of those spoken with confirmed that they did receive their winter clothes approximately one day after they were brought in by their families.

In order to fully ensure the consistent effectiveness of the clothing delivery process for all inmates, the Ombudsman recommended that families delivering clothing parcels to prison should be asked to sign and date a list of the garments delivered. The Ombudsman further recommended that any inmate receiving clothing should be asked to sign and date a list of the delivered items.

Example Three

Complaint about the Confiscation of a Driving Licence

The Ombudsman Office received a complaint that a Traffic Directorate policeman had booked the complainant for a series of infractions that included transporting workers without the proper licence and obstructing traffic by pulling up in a no-parking zone. The policeman confiscated the complainant's driving licence.

The Ombudsman Office launched an investigation and interviewed the traffic policeman. The officer confirmed that he did issue the confiscation order and said that the driving licence was confiscated in response to an order from his senior officer.

The Ombudsman established that Article 74 of Traffic Law No. 9 of 1979 states that *"in all cases in which the law provides the confiscation, suspension or cancellation of the certificate of registration or license or the withdrawal of license plates an administrative decision shall be issued by the Director of Traffic and Licensing or his deputy upon informing him about the violation. The vehicle owner, or whoever is responsible for it, and its driver are immediately notified about the decision."*

The Ombudsman concluded that, in this instance, the correct procedure had not been properly followed and that the confiscation constituted a violation of the law, requiring disciplinary accountability. The Ombudsman also recommended that all officers should be reminded of the requirements of Article 74.

Example Four

Ombudsman Office investigates Arrangements for Supporting Visually Impaired Detainee

The Ombudsman Office, in collaboration with the Saudi-Bahraini Institute for the Blind, investigated the case of a visually impaired detainee remanded in custody, to examine the assistance and support needed for his detention and rehabilitation and the adequacy of the current arrangements.

A team from the Ombudsman Office and an expert from the Saudi –Bahraini Institute for the Blind visited the detainee and assessed all of the areas where special assistance is required. They also checked the inmate's need for medical treatment and the planned schedule of visits from his family.

During their investigation, the Ombudsman Office team spoke with the detainee's family and listened to their observations and views about his needs and requirements whilst in detention. As a

result of the investigation, the team made a number of recommendations for action to the Dry Dock Detention Centre. These included permitting visits by family members without glass separation in order for the inmate to be able to hear his family members more easily and to touch them; ensuring adequate access to bathroom facilities and arranging an appointment with a medical specialist.

The remand centre accepted the Ombudsman recommendations and organised a medical specialist appointment as requested.

The Ombudsman Office has made a commitment to the on-going monitoring of the detainee's well being, in collaboration with the Saudi-Bahrain Institute for the Blind and the administrators at the Ministry of the Interior responsible for correctional and rehabilitation centers.

Example Five

Complaint Alleging Assault by Staff

An inmate at Jau Prison informed the Ombudsman Office through his legal advisor that he had witnessed prison policemen attacking some inmates. The inmate did not, however, identify the attackers or the victims.

The Ombudsman Office launched an investigation and a team visited the prison where they interviewed the complainant witness. The investigators were subsequently able to identify the alleged perpetrators and the abused inmates.

Having examined all of the relevant evidence, the investigation concluded that the Ministry of Interior prison policemen had perpetrated a punishable, criminal act. The Ombudsman Office referred the full case file to the Special Investigation Unit in order

that criminal proceedings would be initiated.

As the victims and witnesses involved in the case were held at Jau Prison where the accused security men were working the Ombudsman Office, conscious of the need to protect the witnesses, recommended that the accused policemen should be transferred to another location in an appropriate post, until the conclusion of the investigation. The Ministry of Interior promptly accepted the recommendation.

The Ombudsman Office further recommended the installation of video cameras in all prison and detention centre buildings, wards and corridors in order to monitor and protect both inmates and prison staff; achieve improved discipline; facilitate the gathering of evidence and avoid unfounded claims.

The Special Investigation Unit referred the accused prison police officers to the court. The trial is still being heard and is being monitored by the Ombudsman.

Example Six

Complaint about Police Attitude to a Member of the Public

A member of the public complained to the Ombudsman Office that a policeman had summoned him to his office, following a verbal altercation between them in a public place, criticised him and blamed him for the earlier disagreement.

The Ombudsman Office launched an investigation and interviewed the complainant, the accused and witnesses. The investigating team concluded that the policeman had not adhered to the law requiring police men and women to show *"dignity and respect*

for their position" and ensure *"the good treatment of the public."*

The Ombudsman Office referred the case to the directorate of military courts for appropriate disciplinary action to be taken.

Disciplinary action was taken and the policeman was issued with a formal verbal warning.

Section Three

Ombudsman Death Investigations

Cases of death in custody investigated by the Ombudsman Office

Cause / Place	Death by suicide	Injury resulting from firearm	Injuries following a traffic accident	Natural causes	Chronic diseases	Drugs overdose	Heart attack following a fight	Negligence/ medicine abuse	Ongoing investigation	Total
Rehabilitation and Custody Centres (Jau (Prison	0	0	0	0	0	0	0	0	0	0
Custody Centre (Dry Dock)	0	0	0	0	0	2	1	1	0	4
Security Directorate	0	1	1	1	0	0	0	0	1	4
Women's Rehabilitation Centre	0	0	0	0	0	0	0	0	0	0
Juvenile care centre	0	0	0	0	0	0	0	0	0	0
Outside Hospital	0	0	0	0	1	0	0	0	1	2
Place of death not yet established	0	0	0	0	0	0	0	0	1	1
Total	0	1	1	1	1	2	1	1	3	11

Death in Custody
Investigation One

Name: Mr A
Age: 35
Cause of Death: Injuries
Following Traffic accident
Date: 29 July 2013
Place: Highway

- The Ombudsman Office became aware of a traffic accident leading to the death of Mr A, a detainee. The Office, exercising its authority to proactively initiate an investigation without a complaint for incidents that would adversely affect public confidence in the Ministry of Interior, immediately opened an investigation.
- Mr A was being transported from the Ministry of the Interior health centre, where he had a medical checkup, to the Samaheej Centre. The driver of the police car in which he was travelling lost control of the vehicle and hit the pavement. This was determined to be due to the driver's inattention and the fact that he was exceeding the speed limit. The accident on the highway in Manama resulted in Mr A's death.
- Investigators considered the concerns of Mr. A's two brothers about the circumstances of the accident.
- The time of Mr A's death was disputed and the Ombudsman started an investigation to determine exactly when the accident had happened.
- The investigators contacted the General Directorate of Traffic and confirmed that the accident happened at 6:30pm. They also contacted the General Directorate of Physical Evidence and found that, at the actual time of them writing the report about

the cause of death, the time of death was not recorded. The report documented only the injuries of the deceased. It was found that the directorate had based its subsequent approximation of the time of death, on a form filled in by the ambulance crew.

- The Ministry of Health was also contacted by the investigating team and provided a report from the Ambulance Department at the Salmaniya Medical Complex. The report noted that the accident was reported at 6:36 pm and that an ambulance left at 6:37 pm. The ambulance returned to the Complex one hour and 13 minutes later, at 7:50 pm.
- Investigators interviewed the driver of the ambulance who said that he and a medic arrived at the accident scene minutes after they received the notification and that they found Mr A on the ground with visible head injuries. They tried to revive him but he was pronounced dead at the scene, shortly after their arrival. Two policemen who were in the car with Mr A were also injured. They were taken to hospital for treatment.
- The medic wrote in the accident report that the death occurred at 5:40 pm, but when he was shown the Salmaniya Medical Complex ambulance report stating that the accident was reported at 6:36 pm, he accepted that he had had recorded the time incorrectly.
- The Ombudsman referred the policeman driving the police car to the security court for trial on the charge of causing the death of a detainee.
- The court sentenced the policeman to six months in jail and imposed several financial fines.

Death in Custody
Investigation Two

Name: Mr. B
Age: 28
Cause of Death: Respiratory Arrest following Medication Overdose
Date: 25 September 2013
Place: Dry Dock Detention Centre

- The Ombudsman Office was informed about the death of Mr B at Dry Dock Detention Centre. A team of investigators attended the Centre and launched an investigation into the death.
- The investigators interviewed the guard security officer, the doctor at the facility clinic and Mr. B's cell mates. At interview, one of the cell mates said that Mr. B had told him that he had taken several medicine/drugs in order to be transferred to outside hospital. Records at the Dry Dock clinic showed that the doctor at the Centre had, in fact, examined Mr B and made a hospital referral. Mr. B was not, however, taken to the hospital, as instructed by the doctor.
- The investigation also established that Mr. B's treatment file recorded that the doctor had referred him to the outside hospital on two other occasions in the two days preceding his death, after he claimed that he had taken multiple drugs.
- The investigation found that the two ward officers at Dry Dock had failed in their responsibility to implement the appropriate procedure, following a doctor request for a hospital transfer.
- The forensic report found that Mr. B's death followed a sharp decrease in blood pressure and respiratory arrest, caused by taking the medication. The report indicated that there was no physical evidence to suggest that Mr. B was subject to any violence.

- Following the investigation, the Ombudsman made the following recommendations to the prison authorities:

  - All the documents related to Mr. B's death should be referred to the Security Prosecution for legal action, on charges of negligence against the two ward officers. (The case is being now reviewed by the court.)

  - Written standards and procedures, detailing clear instructions on the required response to cases identified as needing urgent medical treatment, should be implemented.

  - Written instructions for the arrangements for storing medicines in pharmacy and for administering medication to inmates should be implemented.

  - Appropriate arrangements for the care of inmates at risk of harming themselves or others, should be implemented.

- The Ombudsman Office also referred the matter of the negligence of the two ward officers to the Security Prosecution for the required action to be taken. The case proceedings are still ongoing.

- The Ombudsman Office is following the progress of the case and will inform Mr. B's family of the outcome in due course.

Death in Custody
Investigation Three

Name: Mr. C
Age: 36
Cause of Death: Drugs Overdose
Date: 26 December 2013
Place: Salmaniya Medical Complex

- The Ombudsman Office was informed about the death of Mr C at the Salmaniya Medical Complex. A team of investigators immediately attended Dry Dock Detention Centre where Mr. C had been held and commenced an investigation into the death.

- Investigators examined Mr C's cell and interviewed his cell mates. One of those interviewed stated that Mr. C had been suffering from abdominal pain and that he believed that he suffered from liver disease. He said that Mr. C had attended the clinic regularly. The inmate's cell mates also said that Mr. C died after returning from the hospital where he had received treatment.

- In response to the investigator's questions, the inmates said that some inmates sometimes concealed drugs, obtained during visits, in their mouths, to take them later.

- An examination of the medical and criminal records of Mr. C revealed that he had, in a number of instances, been charged with the acquisition and possession of narcotic substances. He was also found to be suffering from a number of diseases and was receiving treatment for these.

- The investigation found that the Mr C was referred to the Salmaniya Medical Complex on 25 December 2013 where he received treatment and was given a further appointment for the

following day. However, a few hours after he returned to the detention centre, he collapsed. He was taken to the hospital, but died before he was admitted.

- The forensic report concluded that the death resulted from a sharp decrease in blood pressure and respiratory arrest, as a result of the deceased taking morphine and diazepam.
- The Ombudsman Office made a recommendation to all rehabilitation centres to take the necessary precautions and measures to ensure that no non-prescribed medication or banned substances can be brought into the centres.
- The Ombudsman Office decided that no further action or referral for criminal investigation was required in this case.

Death Report
Investigation Four

Name: Mr. D
Age: 19
Cause of Death: Injuries Following Firearm Shot
Date: 8 January 2014
Place: Public road

The Ombudsman Office was informed that, as the police were attempting to apprehend a group of suspects one suspect, Mr. D, had died and another had been injured.

The Ombudsman launched an investigation but, in line with Ombudsman Office Policy, this was suspended when the Ombudsman was made aware that the Special Investigation Unit (SIU) had commenced an investigation.

The Ombudsman Office is currently monitoring the progress of the ongoing SIU investigation and will determine whether further action is required by his Office, when the investigation has reached its conclusion.

Death in Custody
Investigation Five

Name: Mr. E
Age: 49
Cause of Death: Death after a brawl
Date: 8 February 2014
Place: Custody Detention Centre (Dry Dock)

- The Ombudsman Office was informed about the death of Mr. E as he was playing football on the field of the Custody Detention Centre. Investigators attended the Detention Centre and launched an investigation into the death.
- Investigators interviewed detainees who were witnesses to the incident. It was established at interview that Mr. E was playing football when a brawl erupted between him and another detainee, who pushed him to the ground. Mr. E was taken to the medical facility at the Centre.
- The Ombudsman Office team examined the scene of the incident, reviewed Mr. E's medical records and interviewed medical staff about the action taken and procedures followed when Mr. E was brought to them requiring emergency medical attention. The investigators also requested footage from the surveillance camera covering the football field and the Centre medical facility.
- The investigation established that healthcare staff were unable to find a pulse at the time of Mr E's arrival at the medical centre. Cardiopulmonary resuscitation (CPR) was administered and records show that he was promptly moved to the hospital. Unfortunately he was found to be dead on arrival at the hospital.

- According to Mr E's medical records, he was suffering from high blood pressure, heart problems and had experienced chest pains in the left arm and neck. He was being prescribed medication, which records showed was being regularly administered.
- The Public Prosecution launched a criminal investigation into the circumstances of the death and the Ombudsman Office referred all of the evidence collated to them. The Ombudsman Office is monitoring the Public Prosecution investigation and will ensure that Mr E's family is informed of the outcome.

Death Report
Investigation Six

Name: Mrs. F
Age: 52
Cause of Death: Natural death
Date: 11 February 2014
Place: Home of the Deceased

- The Ombudsman initiated an investigation into a press report that a woman, Mrs. F had died after policemen entered her home. The Ombudsman spoke to Mrs. F's husband about the circumstances of the death of his wife.
- An investigation was launched and Mrs. F's husband and her two sons were interviewed. At interview, they said that, at the time of the search, they had heard noises on the roof of their house, followed by knocks on the door. They said that, when they opened the door, they were surprised to find policemen, who had been deployed to their home to look for a wanted person.
- Mrs. F's husband said that the search yielded no result and that, as the policemen were leaving the house, his wife fell to the ground. He said that this happened because his wife was frightened, as well as having a problem with her blood pressure and suffering from a diabetic condition. Mrs. F's husband and sons alerted the policemen and an ambulance was called. Mrs. F was taken to hospital where she was pronounced dead.
- The Ombudsman investigators examined the police records relating to the search and established that the relevant prosecutor's arrest warrant revealed that the wanted suspect lived next door to the complainant's house.

- At interview, the policeman who led the search said that whilst carrying out the orders of the public prosecutor's order to arrest the suspect, they saw him jump from the roof into the complainant's house. The officer said that he ordered members of his team to request permission from the complainant to enter his house to continue their search. He said also that the complainant agreed to the request and that policemen then went into the house. As they completed their search and were leaving, the sons of the deceased asked them to call an ambulance for their mother. When the medics arrived, they found that Mrs. F had died.
- A member of the Ombudsman Office investigation team inspected the houses of the complainant and the suspect and concluded that it would be possible to jump from one roof onto the other as they were of the same height. The complainant had also informed the investigation that the door to the roof of his house was always left open.
- The forensic report indicated that Mrs. F's death was due to respiratory arrest and that there were no suspicions of criminalty. Nevertheless, because of the circumstances of the death the Special Investigations Unit (SIU) carried out a further investigation. The SIU subsequently concluded that no crime had been committed and the Ombudsman, who was monitoring the progress of the case, decided that no further investigation was required by his Office.

Death in Custody
Investigation Seven

Name: Mr G
Age: 23
Cause of Death: Sickle Cell Disease
Date: 26 February 2014
Place: Salmaniya Medical Complex

- The Ombudsman Office was informed about the death of a detainee Mr G, at the Salmaniya Medical Complex.
- Family members of Mr G visited the Ombudsman Office and filed a complaint regarding the circumstances of the death, stating that Mr. G had been subject to physical abuse by the Criminal Investigation Department. (CID)
- The Ombudsman was aware that the Special Investigations Unit (SIU) was investigating Mr. G's death and agreed with the SIU that it would fully investigate the family concerns. It was further agreed that the Ombudsman would carry out a full investigation into the adequacy of Mr G's healthcare.
- Mr. G had been held at Dry Dock Custody Detention Centre prior to his admission to the Salmaniya Medical Complex and, as part of the Ombudsman investigation, investigators attended the Detention Centre.
- Investigators also reviewed Mr G's medical records from the Ministry of Interior's Healthcare Centre at Dry Dock; his medical file from the Salmaniya Medical complex and the forensic report.
- The forensic report indicated that Mr G's death was the result of pulmonary problems, respiratory failure and bleeding in the digestive system as a result of sickle cell disease. The medical notes also evidenced the fact that Mr. G was receiving treatment regularly for sickle cell disease and that his health began to deteriorate after being transferred to outside hospital.
- The Ombudsman determined that this deterioration required further investigation.
- The Ombudsman Office, therefore, sent Mr. G's medical records to the National Health Regulatory Authority (NHRA), the body responsible for regulating the provision of healthcare and ensuring compliance with legal and professional standards in Bahrain, to determine whether adequate and appropriate healthcare was provided at both the Ministry of Interior's Healthcare Centre at dry Dock and the Salmaniya Medical Complex.
- The NHRA formed an independent committee to review the medical records. The committee found that Mr. G was receiving regular and appropriate healthcare and treatment for his Sickle Cell Anemia whilst in detention at the Dry Dock clinic and was transferred to the Salmaniya Medical Complex when this was required. The committee also found that the deterioration in Mr. G's health condition after being taken to Salmaniya Medical Complex was not related to his healthcare in custody. It was found,however, that the cause of death related to a series of errors by the medical team responsible for Mr. G's treatment at the Salmaniya Medical Complex.
- The committee decided to refer the medical team for professional auditing and questioning in special committee and indicated that disciplinary action should be taken against any member of the team found to have delivered an unacceptable standard of care.
- As a result of the committee's finding, the Ombudsman Office referred the case to the Public Prosecution to consider whether criminal proceedings should be instigated.

Death Report
Investigation Eight

Name: Mr H
Age: 40
Cause of Death: Drugs Overdose
Date: 28 February 2014
Place: Custody Detention Centre (Dry Dock)

- The Ombudsman was informed of the death of an inmate, Mr. H, in the Custody Detention Centre. A team of investigators from the Ombudsman Office attended the Centre to commence an investigation into the circumstances of the death.
- Mr. H's cell mates were interviewed and told investigators that, on the morning of his death, Mr. H attended court in connection with his trial. They said that, during that evening, Mr. H went to the bathroom and when he had not returned in a reasonable period of time, his cell mates went to check on him. They found him lying on the floor and attempted to resuscitate him, but he unfortunately died.
- The investigators examined Mr. H's medical file and the forensic report related to his death. The forensic report recorded that Mr. H's death was caused by a sharp decrease in blood pressure and respiratory arrest due to him taking the drugs morphine and diazepam. It was recorded also that no evidence had been seen to suggest that Mr H was a victim of any criminal act.
- As a result of the investigation findings, the Ombudsman Office determined that there was no requirement to refer the case for criminal or disciplinary investigation. The Ombudsman did, however, make a recommendation that the Rehabilitation Centre takes the action necessary to ensure that illicit substances and non-prescribed medicine are not brought into the Centre.

Death in Custody
Investigation Nine

Name: Mr. I
Age: 33
Cause of Death: Acquired immunodeficiency syndrome (AIDS)
Date: 7 March 2014
Place: Salmaniya Medical Complex

- The Ombudsman Office was informed about the death of an inmate Mr I, at the Salmaniya Medical Complex where he was being treated for Human Immunodeficiency Virus infection / Acquired Immunodeficiency Syndrome (HIV/AIDS).
- A team of investigators examined a copy of Mr I's medical records and established that he had been admitted into Salmaniya Medical Complex for treatment for AIDS related pain. He subsequently died at the Complex.
- On the basis of the evidence examined, the Ombudsman Office determined that no further investigation or referral was required.

Death Report
Investigation Ten

Name: Mr J
Age: 49
Cause of Death: Natural Causes
Date: 16 March 2014
Place: Public road

- The brother of Mr. J submitted a complaint to the Ombudsman Office in which he said that his brother died from inhaling tear gas while walking in a public street.
- The complainant told investigators from the Ombudsman Office that his brother was walking in an area where the security forces were firing tear gas to disperse demonstrators. He said that his brother felt weak from inhaling the gas and was taken to Salmaniya Medical Complex. Regrettably, attempts to resuscitate him failed and he died.
- The coroner's report found that Mr. J had *"acute heart problems with complete blockage of the arteries of the heart, which had led to a calcified clot in the main artery, which then caused a stroke leading to the chest pains and other symptoms noted in the earlier medical report."*
- The Autopsy Report concluded that the death had occurred as a result of the complications described.
- Because of the circumstances of the death, an investigation was commenced by the Special Investigations Unit (SIU). The SIU subsequently closed the case stating that no evidence of criminality had been found.

Death Report
Investigation 11

Name: Mr. K
Age: 27
Cause of Death: Injury
Date: 18 April 2014
Place: Salmaniya Medical Complex

- The Ombudsman Office examined a newspaper account of a man, Mr. K, found unconscious in a public area with injuries that appeared to result from birdshot wounds. Mr K was transferred to the Salmaniya Medical Complex.
- An Ombudsman investigator contacted the family of Mr. K to ask for details about the incident. Investigators also went to the Salmaniya Medical Complex, but the doctor responsible for Mr K's medical care said that it would not be appropriate to interview the wounded man. Regrettably the man subsequently died.
- As the Special Investigation Unit had launched an investigation into the case, the Ombudsman Office suspended its investigation pending the outcome of the criminal investigation.
- The Ombudsman Office is monitoring the progress of the Special Investigation Unit investigation and will inform the family of the outcome. If, in due course, the Ombudsman considers that it is required, his Office will carry out a further investigation.

Section Four

Visits to Prisons and Places of Detention

Ombudsman's Visits to Prisons and Places of Detention

1- Prerogatives and References

The Independent Ombudsman Office is responsible for visiting prisons, centres of juvenile care, pre-trial centres and detention centres to confirm that the detention arrangements are legal and that the detainees are not subjected to torture or to inhuman or degrading treatment. These responsibilities are described in Article 12 of Decree 35 / 2013 amending Decree 27 / 2012, which established the Office of the Ombudsman.

The Ombudsman assessment of prisons and detention centres utilises baseline principles, criteria and standards that are consistent with local laws and regulations, including the Prison Systems Law of 1964, and with international covenants used in the inspection of prisons and places of detention, Including those used by Her Majesty Inspectorate of Prisons in the United Kingdom. The Ombudsman Office is the first institution, after the judiciary branch, to have such a prerogative in the Arab world and the Region.

2- The principles and criteria underpinning visits to prisons and places of custody

In September 2013, the Ombudsman Office issued its first version of the principles, criteria and standards to be used for the assessment of prisons and custody centres. The intention was that the assessment criteria and standards would ensure that the 2002 Constitution and its explanatory memorandum, as well as the relevant laws, were fully applied. The standards adopted are consistent also with regional and international conventions and treaties ratified by the Kingdom of Bahrain. These include: the United Nations Charter; the Universal Declaration of Human Rights; the Convention against Torture and the Arab Charter of Human Rights.

The principles are divided into three main sections, each with its set of criteria, as follows:

Principle One: Treatment and Conditions

Areas Covered by the Criteria:

- Respect
- Safety
- Legal use of force
- Physical conditions
- Detainee care
- Detainees food and drink
- Detainees access to outside exercise, reading materials, visits and calls
- Detainee transportation
- Rehabilitation
- Learning, work and skills activities

Principle Two: Individual rights

Areas Covered by the Criteria:

- Rights related to detention
- Appropriate arrngements for detainees who have difficulty communicating
- Legal rights
- Complaints
- Mother and child Unit

Principle Three: Health Care

Areas Covered by the Criteria:

- Health services
- Patient care
- Detainees receipt of prescribed medication
- Psychological health

The Supreme Judicial Council announced on 15 April 2014 its ratification of these principles, criteria and related standards in order to unify the standards applied in connection with prisons related issues, by the judiciary and the Ombudsman.

The criteria and standards will be periodically reviewed and will be amended and developed on the basis of practical experience and new knowledge from other international experience in this field.

3- The Ombudsman Visit to the Correction and Rehabilitation Centre (Jau Prison)

A team of inspectors from the Ombudsman Office visited the Correction and Rehabilitation Centre (Jau Prison) for three days from Tuesday 3 September until Thursday 5 September, 2013. During the course of the visit an assessment was made of the Centre's performance using the agreed principles, criteria and standards.

Information was gathered and examined using a range of methodologies, including detainee interviews. Detainees were selected randomly by investigators to ensure impartiality and objectivity. Interviews took place over the three days of the visit. Interviewees were questioned about a number of areas relating to their conditions of detention, covered by the Ombudsman assessment criteria and standards. These included: their treatment by staff; the application of their legal rights; their experience of healthcare and the facilities and services they were permitted to access. Detainee interviews enabled inmates to contribute directly to the Ombudsman assessment and to influence recommendations for action to improve their conditions of detention.

The inspection team also collected a wide range of documentary evidence, including prison policies and rules and visited all areas of the prison to directly observe conditions and activity.

The findings of the Ombudsman Team visit to the Correction and Rehabilitation Centre (Jau Prison) are documented in the Visit Report. As a result of his findings, the Ombudsman made 13 general recommendations for action and a further five recommendations, specifically concerned with the delivery of healthcare. The visit report is an important reference document for informing the development of reform and rehabilitation centres. The Report is attached at Appendix A.

Section Five

Ombudsman Office Training and International Cooperation

1.Training

The Ombudsman Office is very committed to the development of investigative and support staff and high priority has been given to the delivery of diverse training courses and programmes. The focus has been on the development of professional standards and investigative integrity and, to this end; experts from Bahrain and other countries have participated in training and shared their experience and expertise.

The development of Ombudsman staff knowledge and skills started several months before the official launch of the Ombudsman Office. An early priority was for training to support the implementation of procedures and standards relating to the receipt and processing of complaints against employees of the Ministry of Interior, including complaints from inmates and detainees, and the development of appropriate criteria and standards for visiting prisons, detention centres and juvenile care centres.

The Ombudsman Office partnered with prestigious executive and academic, legal and human rights institutions, with practical experience of working in the fields of inspection, complaint investigation and human rights.

Training over the last nine months has included:

- Basic training in all relevant vocational and management work areas
- Training in all areas of legislation pertinent to the duties and responsibilities of the Ombudsman Office
- Practical training in effective investigation planning and delivery
- Specialist training courses delivered in Bahrain by international experts
- Participation in specialised training courses in Britain and the United States

- Participation in the delivery of prison inspections in Britain

An ongoing process of individual and team training and development needs analysis is now in place.

Examples of Training Programmes and Courses Attended

30 April 2013: Workshop for new employees in which members of Her Majesty's Inspectorate of Prisons in the United Kingdom explained the processes, mechanisms and standards used for the inspection of prisons and detention centres in the UK and shared their extensive practical experience in this field.

26 May - June 3, 2013: Specialised training programme covering the duties, responsibilities and Ombudsman referral mechanism to: the public prosecution; the disciplinary courts at the Ministry of the Interior; the Department of Reform and Rehabilitation (including a visit to Jau Prison) and the General Directorate of Criminal Investigations and Forensic Evidence.

11 – 13 September 2013: Training workshop for investigators covering important technical aspects of investigation planning, delivery and reporting. The workshop was organised in cooperation with the Embassy of the United Kingdom in Manama and delivered by Pauline McCabe, former Northern Ireland Prisoner Ombudsman.

1 October 2013: Training workshop, in collaboration with the International Bar Association "IBA", on "the basic concepts of human rights", aimed at increasing awareness of the fundamental importance of human rights and the significance of human rights to the values of the national and international communities.

18 November 2013: Human Rights Workshop held in cooperation with the Embassy of the Federal Republic of Germany in the Kingdom of Bahrain. Members of the German Foundation for International Legal Cooperation (IRZ) shared German experience and expertise in the area of human rights.

2-3 December 2013: Training Workshop to develop investigative interviewing skills, delivered by Pauline McCabe and Clare McVeigh, Senior Investigating Officer in the Office of the Prisoner Ombudsman Northern Ireland.

29 April 2014: Workshop to consider how to set priorities and address challenges when preparing capacity building programmes in the field of human rights. The Workshop was delivered by the National Institution for Human Rights in cooperation with the Office of the High Commissioner for Human Rights.

2. Visits Abroad:

Delegations from the Ombudsman Office made several development visits abroad. The first of these was to participate in the 10th World Conference of the International Ombudsman Institute held in Wellington, New Zealand, on November 12-16. The Conference was attended by 150 ombudsmen from 85 countries.

Visits took place in the period leading up to the formal launch of the Ombudsman Office in July 2013 and have continued since.

The main objectives of visits have been to:

- Participate in practical training, particularly in the area of prison inspection.
- Take part in conferences, forums and workshops
- Acquire expert knowledge from a range of experienced institutions and organisations in several countries
- Learn particularly about the work of institutions with similar duties and responsibilities
- Share information about the Ombudsman Office in Bahrain as the first of its type in the region.

Examples of Ombudsman Team Visits

21 January 2013: Visits made to the United Kingdom and France, in coordination with the British and the French embassies in Manama. The visits were part of a plan to both learn about UK and France experience and share the early Bahrain experience.

3 June -16 August 2013: Attendance at five specialised training programmes in the United Kingdom delivered, at different times, by Her Majesty's Inspectorate of Prisons. The training was aimed at preparing Ombudsman staff for the inspection of prisons and police stations.

27 September – 6 October 2013: Visit to the United States, in coordination with the US Embassy in Manama, to meet and share experience with international institutions working in the field of police complaints and prison monitoring.

4-9 April 2014: Participation in the International Ombudsman Association Conference in the USA.

28-29 April 2014: Participation in the first Conference of Ombudsman Institutions from the Organisation of Islamic Cooperation (OIC) countries in Pakistan. The conference agreed to set up an Association of Ombudsmen in the Islamic countries.

3. Stakeholder Communication

The Ombudsman has made significant efforts to engage and communicate positively with a wide variety of organisations, agencies, and institutions that have an interest in the work of the Office, especially those working in the area of human rights.

The Office has focused on open communication with:

- Rights organisations
- Embassies
- United Nations Agencies
- Gulf and foreign officials

The Office has recently held a series of meetings with the foreign diplomatic missions in Manama to discuss joint cooperation in the field of training and the exchange of experiences, and to coordinate working visits.

Examples of Stakeholder Engagement

5 December 2012: Meeting in Bahrain with a delegation from the technical team of the Office of the High Commissioner for Human Rights.

9 December 2012: Meeting in Bahrain with US Assistant Secretary of State for Democracy, Human Rights and Labour, USA Michael Posner.

16 January 2013: Visit to the headquarters of Amnesty International in London to meet with officials and members.

27 February 2013: Meeting in Bahrain with a delegation from Human Rights Watch.

27 June 2013: Meeting with the European Union Special Representative (EUSR) for Human Rights, Stavros Lambrinidis and his delegation, during their visit to Bahrain.

10 December 2013: Host to a delegation representing the departments of Correction and Rehabilitation in the Gulf Cooperation Council (GCC), during their visit to Bahrain to participate in the "Second GCC Inmates Week" held on 8 – 11 December 2013.

23 February 2014: Meeting with a technical delegation from the High Commission for Human Rights, led by FarajFneish, the Executive Director of the Middle East and North Africa Department at the UN High Commission for Human Rights.

16 March 2014: Meeting with staff from the US Congress to provide briefing on the responsibilities, tasks and work programmes of the Ombudsman Office.

15 April 2014: Host to a delegation from the UK House of Commons and House of Lords visiting Bahrain.

Section Six

Recommendations

Ombudsman Recommendations

Further to the experience of the last ten months and the information presented in this Ombudsman 2013 / 2014 Annual Report, the Ombudsman is, in line with his responsibility to improve the policy and practice of policing and safeguard human rights, is now making some important new recommendations. The Ombudsman is also taking the opportunity to repeat other high priority recommendations made previously, but not yet fully implemented

1. To ensure that police staff can be easily identified by members of the public and detainees, arrangements should be made for every policeman, policewoman and police officer to have their personal identification number clearly displayed on their uniform.

2. Arrangements should be made for every police vehicle to have its unique identification number prominently displayed.

3. With immediate effect, the Reform and Rehabilitation Directorate should assume full responsibility for the transportation of detainees to outside hospital when attendance for appointments or medical treatment is required and should cease the practice of requesting police stations to undertake this function. An ambulance should continue to be called in the case of medical emergencies.

4. An urgent review of the arrangements for ensuring that no illicit substances or non-prescribed medication can be brought into prisons or places of detention should be completed. Any action required following the review should be taken immediately.

5. The number of doctors, nurses and medical support staff in the Correction and Rehabilitation Centre (Jau Prison) and Dry Dock Detention Centre Clinic Facilities, should be increased in accordance with international best practice standards. Arrangements should also be put in place to ensure that a supply of all required medications is always available.

6. Efforts to provide training for all prison and detention facility staff, and other Ministry of Interior staff, in order to develop their capacity to provide appropriate care and supervision for prisoners and detainees, should be intensified.

7. Urgent action should be taken to address the very serious problem of overcrowding in cells at Jau Prison.

8. The programme of work to locate surveillance cameras in all buildings, corridors and wards in every prison and detention centre, in line with international best practice standards, should be completed at the earliest opportunity.

9. All of the recommendations documented in the Ombudsman Report on the Visit to the Correction and Rehabilitation Centre (Jau Prison), published in September 2013, should be fully implemented.

Appendix 1

Report on the Ombudsman Visit to JAU Prison (september 2013).

Ombudsman's Report on the visit To the Correction and Rehabilitation Centre (Jau Prison)

Report No. 1
3 - 5 September 2013.

Introduction

The Ombudsman assumes the task of visiting prisons, juvenile care centres, pre-trial centres and detention centres to assess the legal detention and that the prisoners are not subjected to torture or to inhuman or degrading treatment, as stated in Article 12 of Decree 35 / 2013 amending Decree 27 / 2012.

The assessment is based on the criteria that are in line with national laws and regulations, including the Prison Systems of 1964, as well as with international covenants used in the inspection of prisons and places of detention, including those endorsed by Her Majesty's Inspectorate of Prisons in the United Kingdom.

In this context, a team from the Ombudsman visited the Correction and Rehabilitation (Jau prison) for three days from Tuesday 3 September until Thursday 5 September, 2013. To assess the implementation of the standards related to humane treatment, the conditions of the centres, and legal rights and guarantees of the prisoners and the health care available.

The prison administration committed to provide all the necessary evidence, including documents, and to facilitate interviews with staff and prisoners alike, which contributed significantly to aiding the visiting team perform their tasks with objectivity and professionalism.

Section 1
Data and information
Principles of the visit:

1. Methodology: According to the criteria and administrative regulations adopted by the Ombudsman
2. Type of visit: Advance notification
3. Access to information through:

A. Interviewing prisoners:

Random samples of prisoners were selected according to the statistical methodology depending on the lists of their names, to ensure impartiality and objectivity.

Many prisoners were interviewed during the field visits carried out by teams from the Ombudsman to the prison. They were questioned regarding a number of issues about the conditions and location of their imprisonment to assess the implementation of major standards established by the Ombudsman such as humane treatment, guarantees and legal rights, health care, in order to have a genuine and objective assessment of their treatment and their conditions, and thus contributes to actions or recommendations that improve them and ensure that the rights endorsed by the laws and regulations in the Kingdom of Bahrain are exercised freely and safeguarded.

B. Documents reviewed:

- Records of meetings and directives
- Staff records to check figures, training and development
- Information and statistics that determine the direction and styles of the administration

C. Staff: Checking with the director or officer in charge to assess the following:

- The development and maintenance of prison buildings
- The presence of trained personnel in all prison suites
- The existence of a plan to manage the risks that may occur in the place.
- Psychological and physical health care for prisoners
- The prisoners' diverse needs and how to meet them.

The principles and standards used for the assessment

Principle 1: humane treatment and conditions

Standard:

- Conditions of the cell and prison facility
- Care for prisoners
- Prisoners are offered sufficient food and drink
- Respect
- Safety
- Legal use of force
- Rehabilitation
- Learning, work and skills activities
- Other requirements (Outside exercise, reading materials, the opportunity to have visits and calls)

Principle 2: Rights and guarantees

Standard:

- Prisoners' legal rights
- Complaints
- Legal procedures related to imprisonment
- Prisoners who have difficulty communicating are provided for

Principle 3: Health Care

Standard:

- Health services
- Patients care
- Prisoners receive prescribed medication
- Mental health

The stages of the visit

1) A formal letter was directed to the Director of the Reform and Rehabilitation Centres at the Ministry of Interior, on 01 September 2013 regarding a visit by an Ombudsman team to the Correction and Rehabilitation Centre (Jau prison).

2) An Ombudsman team went to the prison on on the morning of Tuesday 3 September 2013. The Ombudsman was accompanied by his Deputy, the Director of Complaints, the Director of the Monitoring of Correctional and Detention Centres, the Director of International Cooperation and Development, and members from various relevant departments and divisions.

3) Teams were comprised of inspectors from the Ombudsman, so that each team was responsible for checking the adherence and implementation of the standards between 3 and 5 September.

4) The teams' processes included the following:

- Collecting evidence (documents, the existing administrative system...)
- Conducting interviews (with the staff and prisoners and their visitors).
- Making direct observations.
- Assessing what has been monitored according to the standards.

Basic statistics

Note: The following numbers of officers and members of the police are limited to those who deal directly with the prisoners and do not include those in the security guards and other support services.

1. Number of officers / Shift

Shift	Morning	Evening	Night	Total
Number of officers	4	1	1	6

2. Number of prisoners compared with the intended maximum capacity. The table includes the number of police staff for each building in each shift (05 September 2013)

Building	Total capacity	Actual number	Number of police personnel for each building per shift
1	132	193	3
2	408	511	6
3 Includes category) between 15 and *(21 years old	72	154	2
4	456	612	6
5	112	121	2
6	13	13	1
7	8	4	1
Total	1201	1608	21

* The number of prisoners aged between 15 and 18 was 62.

3. Actual numbers total capacity

- Graphics to compare the number of prisoners with the maximum intended capacity

4. Categorisation of prisoners according to type of felony (5 September 2013)

Case	Premeditated murder	Drugs	Theft	Riots	Others Civil, traffic,) (… residence
Number	30	603	178	465	332

Other felonies include: Financial crimes, traffic, illegal residence …

Section 2

Principles and standards and the extent of their implementation in prison

Principle 1: The humane treatment and conditions

The conditions of the place

- Prisoners are placed in safe cells.
- There are measures to improve the lighting of the cells and facilities with limited natural lighting.
- There are clear shortcomings in the arrangements and maintenance of existing facilities in place.
- There is overcrowding in the majority of cells. Overcrowding ranges from slight to severe.
- Inconsistency in the appropriateness of the temperatures in the cells.
- Prisoners have difficulty in calling emergency personnel.
- Some of the cells do not have toilets inside them.
- Some of the cells and wards have a low standard of cleanliness and hygiene.

Care for the prisoners

- Personal hygiene kits are available.
- Basic requirements for sleeping, such as mattresses, pillows and blankets, are available.
- As a result of overcrowding, there are low levels of comfort among

prisoners during their stay in most of the cells and wards.

- There are not enough beds for all prisoners because their number exceeds the maximum intended capacity of the place.
- There are no specific and clear procedures on how to change the mattresses, pillows and blankets, either after a specific period of time, or in the event of damage or unfitness because of the lengthy use.
- There is difficulty in changing or renewing underwear as new clothes for prisoners are allowed only in exceptional cases. The clothes in the prison shop that prisoners are allowed to purchase do not include all sizes and do not meet the needs all groups.
- There are not enough lockers for all prisoners to keep his personal belongings.

Prisoners are offered sufficient food and drink

- Food and drink are provided for prisoners at meal times.
- There is an appropriate amount of food containing sufficient nutritional value.
- There is no specific method to monitor the quality of food provided by the supplier company and ensure that it is according to stipulations in the supply contract.
- There is no procedure to ensure the arrival of special meals for prisoners that require a specific diet due to health or other recognized reasons.

Respect

- Prisoners are separated based on criteria such as the type of the felonies, the term of imprisonment, the age group (15 to 21 years old), and preventive health isolation.

- There is no classification or separation for the age group between 15 and 18 years old.
- Inadequate and insufficient training programmes for prison staff to develop the skills to deal with and meet the diverse needs of the prisoners.
- There is no social worker at the facility.
- The lack of written procedures governing the process and method of prisoners searches.

Safety

- Prison staff is aware of their responsibility in the assessment and management of risks arising from dealing with prisoners or resulting from prisoners dealing with one another. They are also aware of and understand the concept of self-harm by some prisoners and the danger of some of the prisoners to others and how to deal with it.
- Staff did not receive initial or refresher training on risk management procedures (such as first aid training).
- There are no plans for assessing risk management and periodic follow-up.
- The lack of surveillance cameras in all prison buildings, corridors and wards, which are required under international standards adopted and accepted in this regard.

Legal use of force

- The procedures in prison ensure the appropriateness and proportionality use in cases that require it within the provisions of the law and the relevant regulations.
- Weak theoretical and practical training on how to use force when necessary to ward off risks and maintain order.

- Deficiencies in the documentation of the use of force and its levels in the personal record of the prisoner in the event of his involvement in or being subjected to acts that lead to the use of force.

Rehabilitation

- Prisoners have opportunities to continue their education at various levels according to the home schooling or affiliation systems.
- Prisoners are allowed to study in their cells at any time.
- The existence of a procedure to receive textbooks and deliver them to prisoners.
- Families are allowed to provide prisoners any study books or notes they need.
- Rehabilitation programmes do not cover all categories of prisoners, even those who are serving short sentences.
- There are shortcomings in promoting prisoners' registration in home schooling or affiliation (distance learning) programs.
- The registration process may be lengthy, which may cause prisoners to miss enrolment deadlines to lose their chance to enrol in the school year.

Learning, work and skills activities

- There is sufficient space for purposeful activities.
- Diverse training activities are available in different workshops (panting - carpentry - electricity - arts).
- Some prisoners are hired to perform some simple functions such as washing, cleaning, grooming, for a wage.
- The number of supervisors for the learning programmes, skill acquisition and training of prisoners for employment is not enough.

- There is no clear procedure to take advantage of the spaces allocated for purposeful activities.
- There is no procedure to ensure the effective use of information and data on prisoners for the development of objectives from the educational and the skill acquisition programmes.
- There are no written regulations that highlight to the prisoner his rights and responsibilities in the event of his hiring to a paid job.
- There is no mechanism to motivate prisoners to participate in purposeful activities.

Other requirements (Outside exercise, reading materials, the opportunity to have visits and calls)

- Procedures allow prisoners out of their cells in accordance with the 1964 prison law and systems.
- The facility has different fields.
- Every prisoner has visitation rights in accordance with the 1964 prison law and systems.
- Staffs in the visitation building know how to calm a situation and how to deal and interact with visitors.
- The building for visits is clean, air-conditioned and well-lit. It has a sufficient number of employees and a canteen for the sale of food and beverages for visitors.
- There are no special measures in the visit regulations for visits to persons within the 15-18 age groups.
- There is a deficiency in the available reading material both in terms of quantity and quality.
- The number of telephone booths is not sufficient.

Principle 2: Rights and guarantees

Prisoners' legal rights

- Procedures ensure the prisoners' rights to lawyers and consult them.
- Procedures ensure that prisoners are informed of right to tell their families of their whereabouts.
- Procedures ensure the ability of prisoners or their lawyers to obtain copies of some documents from their records upon their release from imprisonment.
- Prisoners receive a copy of the documents that describe their rights and duties, and in three different languages.
- The instruction documents obtained by the prisoners do not cover all their legal rights and obligations.

Complaints

- Prisoners are encouraged to solve problems amicably before submitting formal complaints.
- Complaints submitted by prisoners are addressed impartially.
- Responding to complaints is relatively slow, and there is no classification of complaints by priority.
- There is no procedure that clarifies whether complaints are resolved orally or in writing.
- There are shortcomings in presenting the information about submitting a complaint or appealing its outcome, through posters, flyers and in the wards and corridors, clearly and in different languages and formats.
- There are no specific procedures to ensure there is no pressure on those who submit complaints is exerted on them to withdraw the

complaint, or measures to protect them or the staff or other people to whom they had referred.

- There is no mechanism for the health complaints system. There are no procedures to facilitate the submission of such complaints or their prompt receptions by specialists.

- There are no methods to inform prisoners about how to submit complaints about health issues.

Legal procedures related to imprisonment

- There are clear procedures and specific legal guarantees to ensure prisoners' legal imprisonment in prison when they come for the first time to the reception venue.
- Accuracy in the validation of the prisoner's documents and details.
- Letter of appeal is presented to the prisoner.
- There is a system of punishment alternatives, in coordination with the competent judicial authorities.

Prisoners who have difficulty communicating are provided for

- Information and guidance are provided in diverse formats and languages

Principle 3: Health Care

Health services

- Caring for prisoners is provided in the medical department or in any hospital outside the facility by specialists in health care.
- The examination rooms are designed in a way that preserves the patient's privacy.
- Health care staffs undergo regular training and have the required knowledge and skills to meet the prisoners' health needs.
- The clinic is open twenty-four hours a day.
- The appointment system has a high degree of accuracy.
- The clinic has a small number of generalists, a dentist, and a psychiatrist
- Medical examinations are confidential.
- There are a small number of doctors, nurses and administrators at the clinic.
- Some medical devices and equipment are out of order or cannot be used. There is no regular schedule for their inspection and maintenance.
- The level of cleanliness of the place is poor since it is cleaned only once a day.

Patients care

- Patients are properly treated when they arrive to the clinic
- There is a medical record for each prisoner that contains the entire medical and health information about his condition and the dates and stages of his treatment

- All contacts between patients, doctors and health care employees are recorded.
- There is coordination between the prison administration and the competent medical authorities outside to complete the treatment of patients with chronic or contagious diseases.
- Prisoners face difficulties accessing care workers and health professionals in a timely manner.

Prisoners receive prescribed medication

- There is commitment to distribute medications on a daily basis.
- Procedures ensure the process of storing, dispensing and disposing of medications safely if not consumed.
- Most types of medications are provided a regular basis.
- The health care specialist moves to buildings to deliver medications to patients according to a prepared list.

Mental health

- Prisoners with mental problems have the ability to go to the prison health facility. The prison administration allows them to communicate with the relevant health institutions that offer them support.
- There are plans and arrangements for the transfer of patients to psychiatry in the cases that require it.
- Clinic staffs undergo training sessions on psychological health issues to enhance their aptitude to deal with relevant problems.

Recommendations

General recommendations

1. Taking urgent action to address the problem of overcrowding in cells. It must be reiterated that the at the time of inspection the facility held 1608 prisoners where its maximum intended capacity was 1201 only.
2. Separating prisoners aged between 15 and 18 years old from the other categories and finding ways to treat them in a manner that meet their diverse needs.
3. Drafting rules that specify the methods and cases of prisoners searches. A team should be trained in accordance with these rules.
4. Modifying the copies of regulations and instructions received by prisoners so as to clarify their rights and obligations clearly and adequately.
5. Setting up clear and specific procedures on complaints, grievances and the protection of complainants.
6. Installing surveillance cameras in all buildings, corridors and wards, according to the international standards in this regard.
7. Drafting written rules to regulate telephones calls and increase the number of phone booths.
8. Maintaining and renovating the wards and facilities periodically.
9. Allocating classrooms to enable students to continue their education, with the adoption of incentives to encourage them to carry on with their learning.
10. Allocating rehabilitation and productive classes to use the prisoners' energies and skills. All prisoners should be included in the programs, regardless of whether their terms are short or long.
11. Holding specialized training sessions for all staff to boost their aptitude to deal with prisoners

12. Increasing the number of staff dealing with prisoners and appointing social workers.
13. Taking the necessary measures to ensure the food supplier/caterer commitment to supply various varieties of foods according to the contract, taking into account the conditions of prisoners with special diets.

Special healthcare recommendations

14. Increase the number of doctors, nurses and administrative staff in the clinic.
15. Take the necessary measures to raise the level of cleanliness in the clinic.
16. Ensure the maintenance and periodic update of medical devices and equipment
17. Develop a mechanism to enable diabetic patients to receive insulin injections.
18. Extend the periods of work in the pharmacy to meet the needs of the clinic.