Prisons & Probation Ombudsman
Independent Investigations

Justice Committee

BY EMAIL

12 January 2023

Dear Justice Committee,

THE PRISON OPERATIONAL WORKFORCE

I am grateful for the opportunity to provide comments on the prison operational workforce for the Justice Select Committee to consider.

My role

The Prisons and Probation Ombudsman (PPO) carries out investigations into deaths and complaints in custody in England and Wales. Our roles and responsibilities are set out in our Terms of Reference[1]. We have three main duties:

- to investigate complaints made by prisoners, young people in detention, offenders under probation supervision and individuals detained under immigration powers.
- to investigate deaths of prisoners, young people in detention, residents in approved premises and individuals detained under immigration powers due to any cause.
- to investigate deaths of recently released prisoners that occur within 14 days of release from prison (except homicide).

The purpose of these investigations is to understand what happened, to correct injustices and to identify learning for the organisations whose actions we oversee, so that we can make a significant contribution to safer, fairer custody and offender supervision.

My submission to the inquiry

My submission focuses on the impact that difficulties with recruitment and retention have on prison regimes. It also considers what more can be done to support operational prison staff so that they can undertake their duties effectively. The majority of evidence relating to the impact of staff shortages is being seen primarily within our fatal incident investigations. However, we are also alert to the impact that staff shortages can potentially have on complaints handling in prisons and the ability of prisons to cooperate with our investigations.

[1] PPO Terms of Reference

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What implications do difficulties in recruiting and retaining operational support grades (OSG) and prison officers have for the ability to provide effective regimes for prisoners?

When investigating deaths in prisons, we will consider and set out the context prison staff work in and, in specific cases, have touched on staffing levels. In our recent investigations, particularly some that we have investigated in 2022, we have taken this a step further because we were able to link the care the prisoners received to the reduced staffing levels.

Key areas where staff shortages are impacting upon the ability to provide effective regimes for prisoners include:

- Assessment, Care in Custody and Teamwork (ACCT) monitoring
- Segregation
- Meaningful activity and employment
- Key worker sessions
- Medical escorts

ACCT monitoring

ACCT monitoring is an important care planning system that supports prisoners at risk of suicide or self-harm. Prison Service Instruction (PSI) 64/2011 requires a multidisciplinary approach for ACCT case reviews, with relevant people involved in the prisoner's care. We have seen examples where, due to staff shortages, staff were unable to fulfil all the duties expected of them, including performing ACCT checks and answering cell bells promptly. Early intervention when a prisoner is found unconscious or in a critical situation might save their life.

Segregation

Segregation inherently reduces protective factors against suicide and self-harm, such as activity and interaction with others. We have seen examples where the segregation unit in prisons has been inadequately staffed and managed. As a result, this has led to prisoners having a lack of meaningful contact with their designated officer (Prison Service Order 1700 requires the designated officer to engage in "purposeful dialogue" on at least three occasions per day), poor record keeping, which is particularly important for the management of segregation, and inexperienced staff being responsible for the unit.

Meaningful activity and employment

PPO investigations have highlighted concerns about the impact of prisons' inability to provide meaningful activity and sentence progression opportunities due to staff shortages. This is particularly pertinent for prisoners serving long sentences and their ability to cope once released into the community. It can have a detrimental impact on a prisoner's mental health and contribute to feelings that they can no longer cope in prison.

The amount of time prisoners spend in their cell and without employment can prove particularly frustrating, inhibiting their prospect of release and ability to prepare for a return to the community. It would be beneficial if, during the transfer allocation process, staff at a receiving prison alerted the sending prison of any limitations on progression activities at that prison. This would enable staff at the sending prison to consider the suitability of the

transfer and manage prisoners' expectations, as it may affect their wellbeing and risk of self-harm.

Key worker sessions

The key worker scheme was introduced as an important part of HMPPS's response to self-inflicted deaths, self-harm, and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners, and helping people settle into life in prison.

Since the rollout of the key worker scheme in 2018, we have seen examples where it has worked well and made a real contribution to prisoners' safety. However, we have more recently found that, due to staff shortages in some prisons, the key worker scheme is not currently available for all prisoners and this has limited the amount of meaningful contact staff are able to have with those in their care. We have seen examples where, had a prisoner received more frequent interaction and support from staff, those officers might have been more aware of their increased risks and be in a better position to consider how to manage them.

Staff shortages have also forced governors to make difficult decisions about what to prioritise. For example, we have often commented on the importance of early days and weeks in custody for prisoners, and it being a period of particular vulnerability for those at risk of suicide and self-harm. Despite this, it is concerning that our investigations have found examples where prisoners had not received a prison induction on arrival due to poor staffing levels and staff were unable to complete all their expected duties.

Medical escorts

We have seen examples where hospital appointments and medical care have had to be cancelled due to staff shortages. As the Justice Committee will note, having held an inquiry into the ageing prison population, staff shortages could present increasing challenges for the prison service to manage older prisoners with greater healthcare needs.

How effective is HMPPS at retaining of OSGs and prison officers, and what more could it to do improve job satisfaction and job morale?

Between 1 January 2020 and 30 November 2022, we have made recommendations concerning the need for staff support following a death in custody in at least 26 cases. Deaths in custody will impact staff in different ways, and it is important that prisons remain alert to the detrimental impact it can have on personal wellbeing and job morale.

While the circumstances of the cases are different, and they occurred before the introduction of the Post-Incident Care Policy Framework in 2022, we have made recommendations that broadly fall into the following categories:

- Holding a post-incident debrief for those involved in the incident to discuss what happened and to offer support
- Inviting relevant staff to a post-incident debrief

- Ensuring appropriate provision of support

Holding a post-incident debrief

On multiple occasions, we found that there was no evidence that a post-incident debrief had been held so it was not clear that staff had been adequately supported.

We also felt that the position in Prison Service Instruction 02/2018 'Post-Incident Care' did not go far enough as actions were only required after violent deaths or other select criteria. Having been consulted on the new Post-Incident Care Policy Framework, we are pleased that the policy now requires action after exposure to any death.

Inviting relevant staff

During our investigations, we have found evidence that some prison staff who had been directly involved in a death in custody had not been invited to a post-incident debrief and so had missed the opportunity to receive post-incident support. This was largely due to staff being busy with other important tasks, such as assisting the police after a death, having to return to their operational role, or having ended their shifts.

The HMPPS policy and guidance on post-incident care states that "only people **directly** involved in the incident should attend" a post-incident debrief. We think that the term "directly involved" should be considered in a broader context so that anyone involved in the immediate response to an event is offered support. For instance, in one investigation, control room staff reported being negatively impacted by a death in custody but they were not invited to a post-incident debrief and did not receive any formal offers of support.

Finally, while this is not always possible, consideration should be given to ensuring that a member of staff not involved in the death in custody leads the post-incident debrief. This allows all members of staff involved to contribute fully to the discussion and to receive appropriate support.

Ensuring appropriate provision of support

For other investigations, where post-incident debriefs have taken place, we have occasionally heard from prison staff that the level of support that they received was not appropriate and was inconsistent. Support is also not always considered during other traumatic stages of a death in custody investigation, such as when identifying a deceased prisoner, during the police or PPO's investigation, or during the Coronial inquest. It would be helpful, if possible, to ensure that support is available and offered at different stages of a death in custody investigation.

Consideration should be given to offering a traumatised member of prison or healthcare staff the opportunity to:

- leave their shift early;
- be moved from the location of the death to another part of the prison;
- be swapped with another member of staff if they were holding a role, such as Oscar One; or

- not be expected to respond to future code blues or reds on the day of the death.

Learning lessons

Finally, I have concerns about the ability of services under considerable pressure to learn lessons or to sustain improvement based on that learning. Our recommendations and thematic lessons often highlight repeat issues. Prisons are not hostile or unsympathetic to what we have to say but we find that issues are not being addressed.

I hope that this is helpful. Please contact me if you require additional information.

Yours faithfully,

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Acting Prisons and Probation Ombudsman

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