Prisons & Probation Ombudsman
Independent Investigations

Annual Report

2020/21

CP 519

Prisons & Probation Ombudsman

Annual Report 2020/21

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by Command of Her Majesty

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CP 519

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Any enquiries regarding this publication should be sent to the Prisons and Probation Ombudsman at:

Third Floor,
10 South Colonnade,
Canary Wharf,
London E14 4PU

020 7633 4100
mail@ppo.gov.uk

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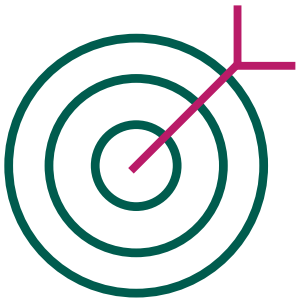
The role and function of the PPO

The Prisons and Probation Ombudsman (PPO) is appointed by and reports directly to the Secretary of State for Justice. The Ombudsman's office is wholly independent of the services in remit, which include those provided by Her Majesty's Prison and Probation Service (HMPPS), the National Probation Service for England and Wales, the Community Rehabilitation Companies for England and Wales, Prisoner Escort and Custody Service, the Home Office (Immigration Enforcement), the Youth Justice Board for England and Wales, and those local authorities with secure children's homes. It is also operationally independent of, but sponsored by, the Ministry of Justice (MoJ).

The roles and responsibilities of the PPO are set out in the Terms of Reference, the latest version of which can be found in the appendices.

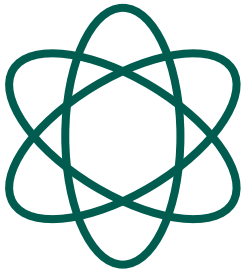
The PPO has three main investigative duties:

* The PPO investigates complaints from young people detained in secure training centres and young offender institutions. Its remit does not include complaints from children in secure children's homes.



Our vision

To carry out independent investigations to make custody and community supervision safer and fairer



Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

Foreword

We have spent the whole of the year covered by this report working remotely due to the restrictions imposed by the COVID-19 pandemic. At the time of writing this report, a small number of our staff continue to go into our offices regularly to print and send the letters that remain our main way of communicating with people in prison and other places of detention. Other than that, our staff have been mainly working from home and we have used email, video and telephone calls to share information, request documents and carry out the interviews that are integral to our work.

For our complaints staff this was less of a shift, as we do not routinely visit prisons in the course of our complaints investigations, unless the circumstances of the complaint require it. However, our fatal incident investigations looked very different when investigators were unable to visit prisons. For many investigations, the opportunity to see where a death has occurred and to have early contact with staff and prisoners is invaluable, as are face-to-face interviews and access to all relevant information and material.

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Without this direct access, investigations had to be conducted remotely. Access in prisons to the technology needed to respond to our requirements has been patchy. Some were able and willing to offer video calls, scan documents and forward information digitally, while others struggled to meet our requests. This sometimes meant we had to rely on telephone interviews and paper documents sent by post and, in some cases, we were unable to access crucial information, for example to view footage from CCTV or body worn video cameras.

As restrictions continued throughout the year, we planned for recovery and an eventual return to our offices although, at the end of the year covered by this report, most of us were still working from home. Our staff have shown impressive flexibility and resilience in the way they have managed the challenges of remote working. Our investigations have been carried out with sensitivity as well as at pace and the impact on timeliness has been far less than might have been expected.

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Access in prisons to the technology needed to respond to our requirements has been patchy.

Despite the obvious challenges of remote working, we recognised that some of the practices we had adopted from the first lockdown had improved how we worked. For example, we had started using the Email a Prisoner service, we had agreed with HMPPS that prisoners could now send us photocopies free of charge and we had strengthened our arrangements for sharing information with other arm's length bodies, notably Independent Monitoring Boards (IMB) and Her Majesty's Inspectorate of Prisons (HMI Prisons). At the time of writing this report, we have agreed we would consider making some of these changes permanent.

Throughout the year, prison regimes were severely restricted as a consequence of the pandemic, but we worked hard to make sure people in prison knew how our ability to respond had been affected and how they could complain to us. Regular broadcasts on National Prison Radio (NPR) and articles in the Inside Time newspaper kept them updated on our work and we used our own newsletter, The Investigator, as well as social media[1] to communicate with our external stakeholders and prisoners' family members.

In December 2020, we published a Learning Lessons Bulletin,[2] available on our website, bringing together case studies and outlining findings and themes from complaints we had received or completed between April 2020 and September 2020, during the early months of lockdown. A follow-up bulletin, due for issue this year, will consider how the longer-term effect of the pandemic has affected the nature of the complaints we receive.

In the year covered by this report, we received 4,010 complaints, 14% fewer than the 4,686 we received in the previous year. We say more about the possible reasons for this fall in numbers in the complaints section of this annual report. As in previous years, most complaints came from men in prison with only a small number being from women or young men under the age of 21. We had expected that with far fewer transfers between prisons and less opportunity for prisoners to move around and mix with others within establishments, we would see proportionally fewer complaints about property. However, property remained the issue on which we completed more complaints than any other, and our uphold rate (where we find in favour of the complainant) was also higher than most other complaint categories. We completed fewer (87) complaints than we anticipated about the restricted regimes operating in prisons and only 17 complaints about visits during lockdown.

1 **@PPOmbudsman** on Twitter.

2 Prisons and Probation Ombudsman (2020), Learning Lessons Bulletin, COVID-19 PPO Complaints. Available online at: **https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2020/12/6.7091_PPO_Learning-Lessons-Bulletin_Covid-Complaints_Draft_v7_WEB.pdf**

This reflected what we heard about high levels of acceptance of, and co-operation with, the imposition of restrictions across the prison estate.

In February 2021, we published another Learning Lessons Bulletin,[3] sharing what we had found in our investigations into the first 26 deaths of people with COVID-19 in the first months of lockdown between March 2020 and May 2020.[4] Our findings are discussed in more detail later in this report. This bulletin is also available on our website and a further bulletin is planned, covering later investigations and lessons learned.

Between 1 April 2020 and 31 March 2021, we started 425 fatal incident investigations, an increase of 37% on the 311 we started in the previous year. The number of investigations into self-inflicted deaths rose by 1, from 84 to 85. Perhaps unsurprisingly, the number into deaths from natural causes showed the biggest increase, rising from 185 in the previous year to 298, which included 132 attributed to COVID-19.

We maintained our focus on the impact of our work, in line with the priorities we identified in our 2019/2021 Strategic Plan and our 2020/2021 Business Plan.[5] This remains a key challenge for us as repeat failings, and the associated need to make the same recommendations in response to what we find, continue to frustrate our work.

Of course, there are also cases where our findings and recommendations result in change for the better. For example, we were pleased to learn that, following our criticism of the care for people with dementia in one prison, a specialist dementia care nurse had been employed. We continued to work with a wide range of stakeholders and academic partners to consider how our reports could have more impact. We also had conversations with services in remit and our sponsors in MoJ about how the services could deliver the changes we all agree are needed to make prisons safer and more decent.

At the time of writing this report, we have conducted investigations into the deaths of two babies, at the request of the Secretary of State for Justice.

I am proud that, during my tenure, we brought people with first-hand experience of prison into the team. We now plan to build on that development by opening up more senior roles to others with lived experience of the criminal justice system and those from other under-represented groups.

3 Prisons and Probation Ombudsman (2021), Learning Lessons Bulletin, COVID-19 PPO Fatal incident investigations. Available online at: **https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2021/02/6.7154_PPO_LL_Bulletin_Covid_Fatal_Incidents_WEB2.pdf**

4 One case was notified to us in June 2020, but the date of death was April 2020.

5 **https://www.ppo.gov.uk/document/corporate-documents/**

During my time as Ombudsman, we have delivered improvements to our processes that have made our investigations more proportionate and ensured that we have operated within the resources allocated to us from public funds. We have strengthened our focus on the work we do to investigate complaints, which typically receives less attention than our more high-profile fatal incident investigations. We have become a more inclusive organisation, still proudly independent but more confident that we can work collaboratively with others to improve outcomes in the services in our remit. A more open and participatory relationship with our sponsors in MoJ has supported the improvements we have made and helped us to strengthen the governance arrangements through which we are accountable.

At the time of writing this report, we are approaching the lifting of the most severe COVID-19 related restrictions. We are hopeful that we will soon be able to resume the work we began at the start of 2020, to carry out a programme of prisoner discussion groups. It remains a PPO priority to understand how prisoners perceive both the internal complaints process and our handling of complaints. We are committed to thinking about whether there are changes we can make to our processes, or how we communicate with complainants.

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We have become a more inclusive organisation, still proudly independent but more confident that we can work collaboratively with others to improve outcomes in the services in our remit.

We have also begun thinking about the way that different groups of complainants view the complaints process and the PPO. We want to understand why we receive and complete few complaints from women in prison, young people aged 21 and under, from those under probation supervision and in immigration removal centres.

We are hoping to work with the charity Women in Prison to contribute to their magazine for prisoners, in the same way that we contribute to Inside Time. We know that we need to raise our profile with women in prison, and plan to carry out specific discussion groups in women’s prisons.

Through our work with Revolving Doors Agency (RDA), we have already held one virtual discussion group with people under probation supervision. We are keen to continue that work to understand the barriers to making complaints that those under probation supervision perceive. We are also looking at ways we can contribute to the restructure of national probation services to ensure that all those subject to probation supervision understand how to make a complaint to the PPO.

We are in the early stages of thinking about how we can bring together those who work with or represent young people aged 21 and under in prison, to learn from each other and identify good practice in complaint handling. We plan to review how we carry out our investigations into young people's complaints, and how we report our outcomes to them.

Having successfully bid for additional funding to investigate the deaths of people after their release from prison, we are doing more detailed planning to decide which post-release deaths will be subject to our investigations. We will focus this work to make sure that the learning we identify can inform changes in practice to make the early days after release safer and reduce the number of preventable deaths.

We will now expand our Terms of Reference to include some post-release deaths, as well as all neonatal deaths that occur in prisons.

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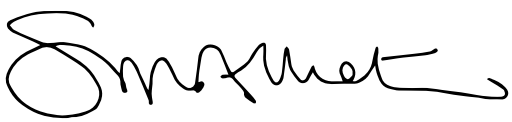
Our focus on the impact of our work will continue as we plan for our return to more normal working arrangements and look forward to going back into prisons on a regular basis. I am very grateful to all of my colleagues for the way they have responded to the considerable challenges they have faced in the year covered by this report and I am confident we will show the same commitment to robust, impartial and independent scrutiny in the future.



Sue McAllister CB
Ombudsman

The year in figures

Complaints

Complaints received

In 2020/21 we received **4,010 complaints**, a **14% decrease** compared to last year.

Of these:

3,722 were about prisons, **646** fewer than last year

282 were about probation services, **12** fewer than last year

4 were about immigration removal centres, **19** fewer than last year

2 were about secure training centres, **1** more than last year

Eligible complaints and complaints started

We sent out:

4,652 eligibility letters to complainants in 2020/21,*

a **17%** decrease compared to last year

In **2020/21** we started investigations into **1,682** cases compared to **2,203** cases in the previous year, a decrease of **24%**

* Timeliness for these letters are unavailable due to ongoing work with a new case management system, however, this is hoped to be resolved in the near future. Refer to the About the data section for definitions of eligibility, upheld and not upheld cases.

Complaints completed

In 2020/21 we completed **1,572** investigations[6] compared to **2,450** in the previous year, a decrease of **36%**.

Of these:

Property
35%
the most common complaint category

Staff behaviour
8%

Categorisation
7%

30%
of all completed cases were found in favour of the complainant, similar to the rate of **31%** last year

Closed complaints

We do not investigate eligible cases if, for example, the complaint does not raise a substantive issue or if there is no worthwhile outcome. This helps us to appropriately allocate resources.

Of the cases we closed in 2020/21:

201 declined

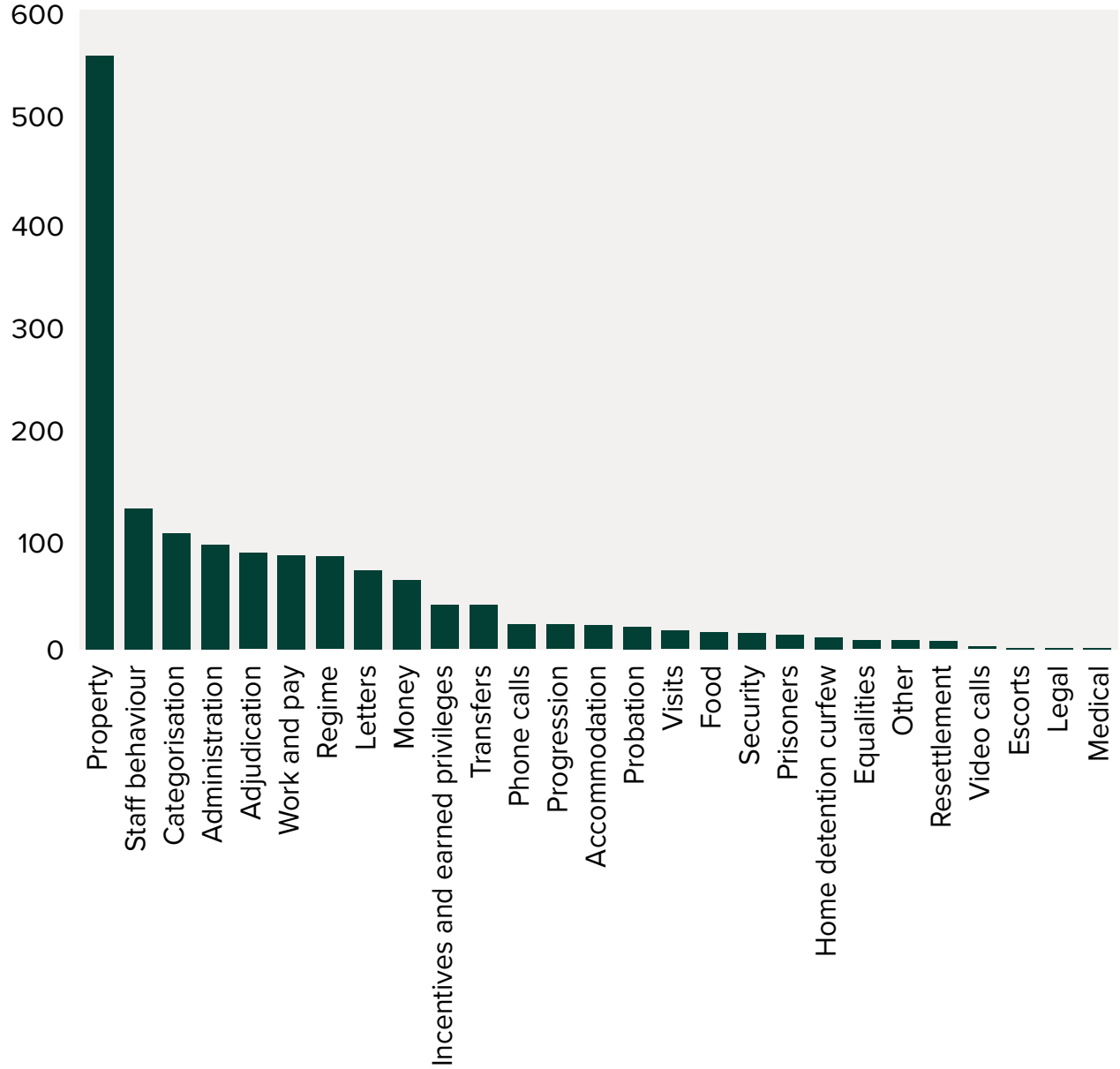
201 complaints were declined for investigation, **84** fewer than last year

39 withdrawn

39 complaints were withdrawn this year, this includes complaints withdrawn by the PPO and by the complainants themselves

6 Due to moving to a new case management system, work is still ongoing for producing timeliness statistics for completed investigations.

Complaints completed in 2020/21 by category:



Fatal incidents

Investigations started

In 2020/21, we started investigations into **425 deaths**, a **37% increase** compared to the previous year. We began investigations into:

298

deaths from natural causes, 113 more than last year

of these **298** deaths, **132** were related to COVID-19, compared to **4** last year

30

other non-natural deaths, 8 fewer than last year.* However, it is important to note that, at the time of writing, there are **11** deaths awaiting classification (which tend to be classified as other non-natural)

1

apparent homicide, 1 less than last year

85

self-inflicted deaths, 1 more than last year

* Please see the About the data section for more details and definitions. Most 'other non-natural' deaths are drug related.

Of the **425 deaths** in 2020/21, the location of investigations started consisted of:

405

prisoner deaths, 115 more than last year

15

deaths of residents living in probation approved premises, 2 fewer than last year

1

death of a resident of the immigration removal estate, equal to last year

4

discretionary cases

- the death of an individual who was admitted to hospital following a fall in prison where they died after being formally released
- the death of an individual who was released on compassionate release from hospital to his family's address for 11 days until his death
- the death of an individual who was found hanging in their cell but remained in hospital after their release on compassionate grounds until their death
- a stillbirth in prison at the request of the Secretary of State for Justice

Reports issued

This year we issued **292 initial** and **298 final reports** compared to **343** initial and **342** final reports last year. In 2020/21:

70%

of initial reports were on time, compared with **80%** last year

58%

of final reports were on time, compared with **66%** last year

21 weeks

was the average time to produce an initial report for a natural cause death

28 weeks

for all other deaths

754

fatal incident investigations not yet published on our website (as of 31 March 2021). This includes:

- investigations where we have not issued a final report and we are still investigating
- cases where we have issued the final report, but we are awaiting notification that the coroner's inquest has concluded in order to publish the report
- a small number of reports waiting to be published

949

recommendations made by PPO following deaths in custody related to (among other subjects):

273

healthcare provision

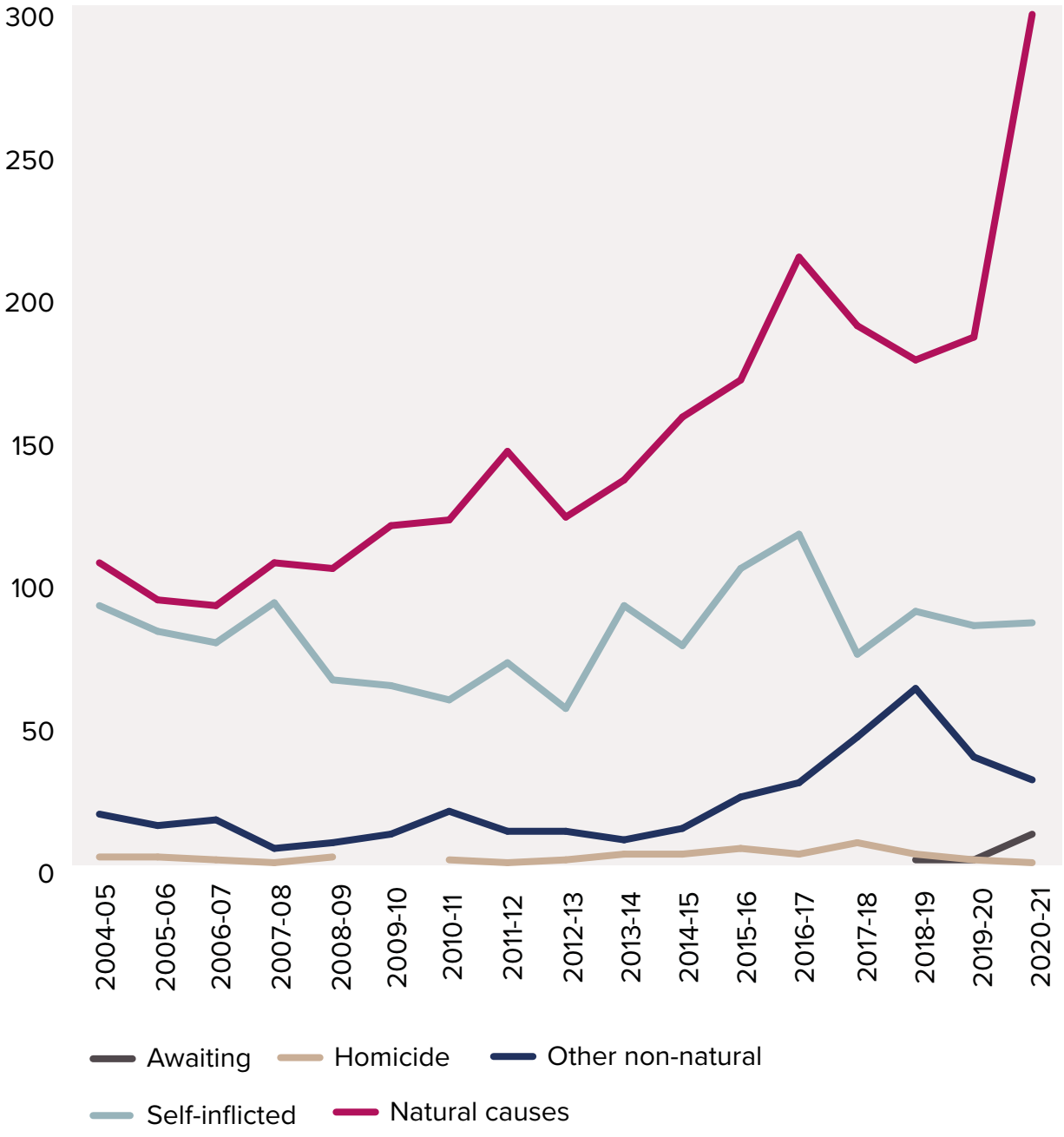
149

emergency response

127

suicide and self-harm prevention

Fatal incidents investigated



Investigating complaints

For the complaints team, the focus of the year was about being adaptable and flexible as we, and our services in remit, dealt with the unprecedented challenges of the COVID-19 pandemic.

The severe national restrictions imposed in March 2020 necessitated an urgent rethink about how we carry out some of the most basic aspects of our work. Most of the complaints we receive are submitted by letter, arriving by post at our office in Canary Wharf. The national lockdown meant that our office building closed and all staff began working from home. This meant we could not access our post and process new complaints received in the normal way. Within eight weeks of the lockdown, we had diverted our post to a secure scanning company which scans each item and sends us electronic copies.

Not being able to access our offices, and therefore our printers and our official stationery, forced us to reconsider how we communicate with people in prison – which has historically been through hard copies sent in the post. In June 2020, we trialled using Email a Prisoner to email eligibility decisions and some outcomes to prisoners. Given the sensitive subject matter of many of the complaints we receive and the non-confidential nature of Email a Prisoner, we have been careful to ensure that anything we send using this method is suitable and will not compromise anyone's safety or wellbeing. Up to the end of March 2021, we had sent 3,692 emails to prisoners.

Identifying ways to modernise our approach to our work, including reducing our reliance on paper, is one of the commitments of our 2019/2021 Strategic Plan. Our updated complainants' survey now includes a question about the use of Email a Prisoner and we will use that data and other sources available to consider whether and how we continue to use Email a Prisoner.

Throughout the year, the assessment team has continued to deal with the messages left on our voicemail service and sent to us by email. Particularly at the beginning of the reporting year, coinciding with the beginning of the pandemic, the messages received clearly conveyed the fears and anxieties of complainants and their friends and family. We did not change very much the way in which we dealt with these messages; we have always raised urgent safeguarding concerns directly with prisons and tried to signpost callers and those who email us to the right organisations to help them. However, we did recognise the need to strengthen our information-sharing relationships with other scrutiny bodies like HMI Prisons and the IMB, and organisations such as The Prison Reform Trust and RDA. Doing so has, we think, better equipped us all to do our jobs. For the PPO, the benefits have been in understanding which elements of prison regimes were most affected by the restrictions and adapting our approach accordingly.

In May 2020, the Prisoner Advice Service (PAS) contacted us to highlight several recurring problems being raised by callers to their advice line relating to the impact of COVID-19 restrictions. They told us that prisoners were reporting difficulties accessing complaint forms, and slow responses when they submitted complaints. In response, we contacted the governors and directors of all prisons in England and Wales to check to what extent they were operating normal complaint processes. The responses allowed us to adapt our processes in some cases (for example, when we were advised of severe staff shortages affecting complaint response times) or to hold the prison to account when they told us they were operating a normal service and this was not reflected in the way complaints had been handled.

PAS raised some issues specific to individual prisons, and some general concerns about prisoners' wellbeing. We shared this information with the complaint teams responsible for investigating complaints from those prisons, as well as with HMI Prisons and the IMB. We agreed to work with PAS to raise urgent safeguarding concerns with our contacts at the relevant prisons.

This reporting year, we received 14% fewer complaints than last year. The reasons for this reduction are likely to be many and varied. It might reflect positively on how HMPPS managed the challenges and dealt with prisoners' concerns, or it might relate to access to or understanding of how to make a complaint. There has been a reduction in the number of HMPPS complaints in the last year.[7] In the 12 months to 31 March 2021, there were around 178,100 complaints. This compares to around 202,200 in the 12 months to 31 March 2020, a reduction of 12%. It is likely there many complex reasons for the reduction in the number of HMPPS complaints; it may in part be linked to the 6% reduction in prison population in March 2020 compared to March 2021.[8]

We plan to analyse our own data to understand better the characteristics of those who complained to us this year. In 2020/21 we received 4,010 complaints and we accepted 1,682 complaints. Year on year, we find a consistently high number of the complaints we receive to be ineligible for investigation. Of the complaints we received in 2020/21, the most common reason for being ineligible was that the complainant had not followed the correct procedure. This is undoubtedly frustrating for those who make the effort to refer their complaint to us, and frustrating for us. We commit considerable resource to assessing the eligibility of incoming complaints, resource we would prefer to divert to carrying out investigations.

7 See the About the data section for more details.

8 **https://www.gov.uk/government/statistics/prison-population-figures-2021** and **https://www.gov.uk/government/statistics/prison-population-figures-2020**

Mr A wrote to us to complain that his prison file contained incorrect information about him. He asked what he could do to correct the information. Mr A did not provide us copies of his complaint forms or the HMPPS responses, and so we could not establish that he had completed the internal complaints process. Under our Terms of Reference, we are unable to investigate a complaint until the complainant has exhausted the internal complaints process. We wrote to Mr A explaining the steps he needed to complete before referring his complaint to us.

Our Terms of Reference also allows us to decide not to investigate an otherwise eligible complaint if we consider that no worthwhile outcome can be achieved, or the complaint raises no substantial issue for investigation. We make such decisions carefully, but it is important that we use our resources proportionately and focus on those complaints where we are likely to have most impact, either for the individual complainant or on a wider point of policy.

Mr B complained that the prison had not supplied him with the Royal Mail Recorded Delivery reference numbers for three recent letters he had sent. He said that without the reference numbers, he had not been able to check the letters had arrived at their destinations. Dissatisfied with the prison's response to his initial complaint, he appealed. In response, the prison confirmed that one of the letters had been sent by Recorded Delivery and supplied the reference number and confirmation it had been delivered safely. The prison could find no record of the other two letters mentioned in the complaint. They gave Mr B advice about how to ensure this did not happen again and apologised for any inconvenience Mr B had experienced. Mr B remained unhappy with the reply and referred his complaint to the PPO.

Mr B's complaint was eligible for investigation. However, we concluded that the prison's response was reasonable and that a PPO investigation was unlikely to achieve anything more. On that basis, we declined to investigate the complaint.

> … it is important that we use our resources proportionately and focus on those complaints where we are likely to have most impact, either for the individual complainant or on a wider point of policy.

In 2019/20, we began to work closely with NPR and Inside Time. This year, we have continued to publish monthly articles in Inside Time and air regular adverts through NPR. We have focused on sharing basic information with prisoners, particularly those new to prison life and experiencing a curtailed induction process, about who we are and how to make an eligible complaint. We have also been able to highlight important changes, such as the agreement we brokered with HMPPS to ensure prisoners could have their complaint forms photocopied free of charge. We have also been working with HMPPS to devise training material for new prison officer recruits to raise awareness among prison staff of the PPO and the roles we perform.

COVID-19 complaints

In December 2020, we published a Learning Lessons Bulletin focusing on the impact of COVID-19 on our complaints work. We had to devise new processes for identifying and investigating complaints about or directly related to the impact of the pandemic, and the changes to policy and practice introduced at speed by the services in remit.

Since May 2020, we have separately identified COVID-19 complaints so that we could monitor the impact on complaints received and investigated. The PPO defines a COVID-19 complaint as one in which the complaint mentions COVID, COVID-19, coronavirus, pandemic or epidemic in the complaint forms, or if the complaint relates to changes in policy or practice due to COVID-19.

In this reporting year, we received 152 COVID-19 related complaints. The largest single category of COVID-19 complaints received was about the impact of the pandemic and the resulting restrictions on prison regime.

Mr C complained to the PPO in June 2020 that he had been denied time in the open air for a period of seven days, due to a local policy of applying 'sanctions' to manage prisoners' negative behaviour. The prison replied to his initial complaint telling him that, during the pandemic, prisons could apply sanctions such as removing time in the open air, exercise and use of in-cell computers to manage poor behaviour.

We knew that PAS had written to the governor to challenge the use of such sanctions. We asked the prison for a copy of their response to PAS, and information about which residential unit Mr C was now living in and whether he was able to take exercise. Although the prison's response to our requests for information was unsatisfactory, they did confirm that they had discontinued the sanctions policy in early May 2020 because it was inappropriate.

We sought advice from the relevant HMPPS policy team, who confirmed that prisons were not entitled to withdraw exercise or access to the open air as a punishment. They confirmed that, throughout the early stages of the pandemic, and at the height of restrictions, emerging policy included mandatory actions to protect prisoners' access to time in the open air.

Mr C had been released from prison before we completed our investigation, and we did not have a forwarding address for him. However, we felt the complaint raised serious issues and so we highlighted our concerns about how the prison had handled Mr C's complaint and the sanctions policy to the HMPPS Prison Group Director.

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We had to devise new processes for identifying and investigating complaints about or directly related to the impact of the pandemic, and the changes to policy and practice introduced at speed by the services in remit.

An emerging area of COVID-19 related complaints relates to work and pay. As has been the case outside prison, prisoners' access to work has been significantly disrupted by the restrictions imposed as a result of the pandemic. Some prisons furloughed prisoners, and most came to alternative arrangements for paying prisoners for work they were unable to complete.

Mr D complained that, at the end of April 2020, he had been removed from his job as a wing cleaner for allegedly breaching the two-metre social distancing rule when he went into another prisoner's cell. Mr D agreed that he had entered another prisoner's cell but said that he had not breached the two-metre rule at any point.

We found that the prison had issued a Notice to Prisoners in March 2020, advising them of the importance of remaining at least two metres from other people and that they could face sanctions for deliberately disobeying the rule. We concluded that the prison had made clear that a single serious incident could result in removal from employment, and also that prisoners removed from work for this reason would receive nil pay.

We considered whether the prison's zero tolerance approach was appropriate and noted that the incident had occurred at the beginning of the pandemic, when prisons were dealing with unprecedented challenges. We concluded that, given the broader national context, we could not say the prison had been unreasonable in its actions. We did not uphold Mr D's complaint.

During the pandemic, many prisoners' progression has been severely impacted, for example because of a lack of access to psychological services required to complete behaviour assessments, or delays in transfers to lower category prisons. While it is very difficult to accurately predict future trends in complaint themes, we suspect that we will see an increase in complaints about how the pandemic has affected prisoners' progression through prison and towards release.

The following case study reflects the knock-on effects of delays to the criminal justice system more widely.

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During the pandemic, many prisoners' progression has been severely impacted...

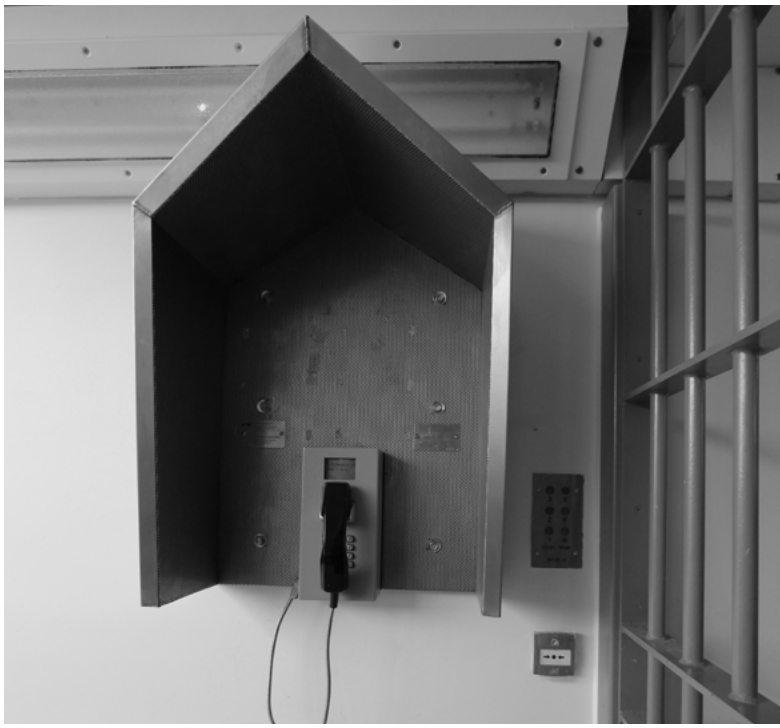
In December 2020, Mr E complained to the prison that he had been recalled to prison 10 months earlier, had not been charged with any new offences, and was being held in a category C prison. He complained that he was due a categorisation review and was suitable for category D conditions.

The prison responded to Mr E's original complaint and said that the police were investigating possible further offences, and that charges were likely. This meant that Mr E was not suitable for open conditions.

When we accepted Mr E's complaint for investigation in January 2021, we asked the prison whether Mr E had been charged with any further offences and noted that he had been recalled to prison on suspicion of further offences in November 2019. The prison told us that the matter had been referred to the Crown Prosecution Service (CPS), but that the pandemic was causing the CPS delays outside the prison's control.

In any case, we found that the relevant prison policy allowed for prisoners to be kept in closed conditions even if they had not been charged with further offences. We concluded that the prison's decision not to reduce Mr E to category D was reasonable. We did not uphold Mr E's complaint.

Some of the emerging policies introduced to deal with aspects of the pandemic have had unintended consequences. Early in the pandemic, HMPPS stopped allowing prisoners face-to-face visits with family and friends. Aware of the potential impact of such restrictions on family ties, HMPPS decided to provide every prisoner with £5 per week of telephone credit to ensure that they could make telephone calls in the absence of visits. Normally, prisoners are expected to pay for their telephone calls with their own money. However, not all prisoners made regular calls, and as the balance in prisoners' telephone accounts grew, HMPPS clarified the policy, resulting in a number of very similar complaints.



Mr F complained about the prison's decision to cap telephone account credit at £20. Mr F argued that once HMPPS had placed the weekly £5 allowance into a prisoners' account, it became the prisoners' property. He said that he should have been able to transfer the money into another of his prison accounts (to buy toiletries or additional food, for example) and that it should have been available to him on his discharge from prison.

We reviewed evidence, including a Notice to Prisoners issued by the prison, confirming that telephone credit added by HMPPS could not be transferred to another account, or issued as cash on discharge. The Notice confirmed that this did not apply to credit added by the prisoner himself.

We concluded that the prison's actions were compliant with national policy and reasonable and did not place Mr F at any disadvantage. We did not uphold the complaint.

We plan to issue a follow-up Learning Lessons Bulletin in 2021/22, analysing the growing body of COVID-19 complaints. We are also committed to continuing to think about what our data does not tell us about the experiences of those in the criminal justice system – arguably as important as what it does tell us. We will also need to think about how we move from identifying COVID-19 related complaints, to understanding the long-term impacts of the pandemic on prison life and the nature of complaints made to us.

Digitalisation

During the reporting year, circumstances drove many organisations, including HMPPS, to find digital solutions for both new and existing problems. One such solution was the introduction of video calls, via a private company called Purple Visits, to replace in-person visits. While we welcomed the move to help prisoners to maintain important family ties, we remain clear that video calls are no substitute for in-person visits. Additionally, we continue to monitor incoming complaints to ensure that the opportunities to have video calls are distributed evenly across the prison population and that risk assessments are carried out fairly and transparently.

Mr G, who had been imprisoned for offences under the Terrorism Act and was allowed in-person visits, complained that he was denied video calls in July 2020 because he had failed the HMPPS risk assessment.

In response, the prison said that video calls posed different risks to in-person visits, including that staff could not be sure who was in the room during the call and that third parties might unlawfully record the video call. The prison said that the risk assessment included consideration of the prisoner's offence and security category, the level of public interest and risks associated with giving the prisoner access to IT.

Mr G appealed on the basis that the risks he posed were no different to any other prisoner. In response, the prison said that his knowledge of IT and his index offence, and two instances where Mr G had allegedly failed to comply with HMPPS policy during telephone calls, meant that he was not suitable for video calls. Mr G referred the complaint to the PPO.

Our investigation centred on the reasonableness of the assessment of Mr G's risk. From the information provided by the prison, we concluded that whether or not Mr G had IT expertise, it was extremely unlikely that he could breach the computer security during a video call. We also considered Mr G's alleged breaches of the telephone compact. We questioned the extent to which they were relevant to the risk assessment.

HMPPS guidance makes it clear that prisoners do not have a right to video calls, however we were not persuaded by how the prison had conducted and presented Mr G's risk assessment. We concluded that the decision-making process to not allow Mr G video calls was unreasonable. We are not, however, in a position to comment on whether Mr G should have been allowed video calls, as that is rightly a decision for the prison. We upheld Mr G's complaint and recommended that the prison undertake another risk assessment to determine his suitability for video calls. HMPPS accepted the recommendation and Mr G has since been able to make video calls.

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...we remain clear that video calls are no substitute for in-person visits.

Previous annual reports published by the PPO have highlighted the volume and importance of complaints related to damaged or lost property. As noted in the foreword, despite the pandemic, property complaints remain the largest single category of complaints received in 2020/21. We have written extensively in various communications about the common issues these complaints raise – and our frustrations with that. We were pleased to be invited to comment at the very end of the reporting year on a new HMPPS Property Framework to replace the existing Prison Service Instruction. We are hopeful that our contribution, which is based on our extensive experience of dealing with property complaints, will lead to a much-improved policy.

During the year, Serco, the private company with contracts to manage several prisons in England, introduced digital property cards. We received a few property complaints where digital property cards had been used.

Mr H complained that items of his property had gone missing. He said that he had assaulted an officer and so was moved to prison A's segregation unit and, shortly after, transferred to prison B. As a result, he did not pack the belongings in his cell on the wing himself. At the point of transfer to prison B, he realised that most of the property in his cell had gone missing. Prison A could not supply a completed Cell Clearance Certificate, a form staff must complete if they pack a prisoner's property without the prisoner present. We compared the property listed on the prisoner's property cards at prison A and that on the digital property card at prison B. We were satisfied that the property had not transferred from prison A to prison B and that prison A was responsible for the loss. We mediated with prison A and they agreed to pay Mr H compensation for the missing items.

The prisoner had transferred to a Serco-managed prison with digital property cards. The digital property cards made it much easier for us to compare the property that was listed, without having to decipher handwritten entries, or account for crossings out and corrections. We found it quicker and easier to resolve the complaint.

We welcome HMPPS' commitment to digitalise aspects of the property handling process but understand that there are no imminent planned changes. We will continue to monitor the impact of digital property cards on our ability to resolve complaints.

Poor complaint handling

In past years, we have written about how often our investigations highlight poor complaint handling practices in prisons. In 2019, HMPPS issued the updated Prisoner Complaints Framework to replace the existing Prison Service Instruction. The aims of the policy update were to:

- support staff to resolve prisoners' issues fairly and effectively at an early stage to try to avoid follow-up complaints, appeals and costs arising from litigation claims
- implement Lammy Review recommendations in relation to ensuring staff apply a problem-solving approach, and the correct burden of proof when investigating issues
- have procedural justice principles running throughout them to help increase prisoners' confidence and understanding about the fairness of the process[9]

Of course, the nature of our work means that we only see those cases where the complainant remains dissatisfied. This reporting year, we upheld 30% of the cases we completed (similar to last year's uphold rate of 31%), so in many cases we find that the prison responded to the complaint appropriately and reasonably. However, there are still too many examples of careless or policy-non-compliant complaint responses.

The following case study, relating to a complaint about staff behaviour, is a good example of where an initial and, to an extent, understandable human error in the first complaint response was compounded by insufficient quality assurance on appeal.

Mr I complained about the behaviour of a named officer. He said that the officer had been rude to him on one occasion, used a derogatory term to describe another prisoner on a second occasion, and had been rude to his sister when she had visited him on a third occasion. He gave specific dates for two of the examples.

A prison manager replied that they had spoken to the officer in question who could not remember any of the incidents. The manager also said they had checked the staff rota for the two specific dates and the officer was not on duty on the first, and not working in the visits' hall on the second. The manager suggested Mr I had mistaken the officer's identity.

Mr I appealed and, in response, a governor said that Mr I's complaint had been thoroughly investigated and suggested Mr I talk to the prison manager about how to develop constructive relationships with staff. Mr I was unhappy and referred the complaint to the PPO.

9 https://www.gov.uk/government/publications/prisoner-complaints-policy-framework

Using the information Mr I provided about the officer in his complaint, we asked the prison to check again whether the officer was on duty – and where – on the dates in question. The prison confirmed that the officer had been working and had been on duty in the visits' hall as Mr I had said. The manager who had originally responded to Mr I's complaint acknowledged that he had checked the working pattern of another officer who shared the same surname.

We concluded that the correct course of action was for the prison to re-investigate Mr I's original complaint about the officer's behaviour towards him. (We noted that the other two incidents concerned how the officer had treated third parties and, unless the individuals wished to make complaints themselves, were outside the remit of both the internal HMPPS complaints process and the PPO's Terms of Reference.) We also recommended that the prison apologise to Mr I for mishandling his complaint and remind staff of the importance of responding to complaints accurately, carrying out quality checks at all stages of the complaint process. HMPPS accepted the recommendations.

Some complaint investigations highlight a litany of failings, in terms of how the subject of the complaint came about, and then how the complaint itself was handled.

Mr J complained that three pairs of glasses and some picture frames had been damaged when he transferred between prisons. He said that, on his arrival, he collected his property from reception, accompanied by an officer. Mr J said that the officer saw that the items were damaged. Mr J asked for compensation to cover the cost of the items.

In an interim response, the prison wrote that the officer had confirmed the items were damaged when Mr J received them from reception staff. Staff said that they would investigate the matter further with reception officers and provide Mr J with a final response.

Several weeks later, Mr J received a final response to his complaint. The officer responding said that Mr J had been at the prison for several weeks before he complained about the damaged property and, given how long the items had been in Mr J's possession before he complained, they could not say that the damage had been caused during the transfer and did not uphold the complaint.

Mr J appealed and a governor replied that the prison could not be sure that the damage had not occurred at Mr J's previous prison. They suggested Mr J complain to that prison. Mr J asked the PPO to investigate.

We noted that Mr J's property cards at his previous prison had recorded the glasses but not that they were damaged in any way. The officer who had witnessed Mr J checking his property confirmed that, at this point, the glasses and picture frames were indeed damaged. We found that Mr J's property had not been managed in line with HMPPS policy, so it was difficult to assess where the damage had occurred. However, on the balance of probabilities, we concluded that, given how Mr J's property had been managed at the receiving prison, the damage had occurred while it had been stored in reception. We recommended that the prison ensure Mr J received replacement glasses.

We were also critical of how the prison had handled Mr J's complaint. The final response made no reference to the fact that an officer had witnessed Mr J checking his belongings and discovering the damage. We also noted that, according to HMPPS policy, it was the prison's responsibility – not Mr J's – to refer the complaint to the sending prison, if they thought that was appropriate. We made several recommendations about ensuring Mr J received new glasses, and that staff understood how to manage prisoners' property and respond to complaints in line with HMPPS policy.

Failing to resolve issues at an early stage

We are often surprised by the nature of the complaints we receive. Not about how they were handled (as described in the preceding section), but that the issue needed to result in a complaint at all. Some of the complaints we receive relate to incredibly straightforward situations, which could and should have been resolved with minimal effort by prison staff. These are frustrating for us to investigate, highlighting the waste of resource, and therefore public money, being spent resolving basic issues. They take us away from those serious complaints that deserve our attention. The following case study was a staggering example of this.

Mr K complained that his stereo, speakers and other items had gone missing when he transferred between two prisons. He said that he had been told his stereo was still in a wing office at the sending prison, but he had not yet received it at his new prison. Unable to resolve the issue, Mr K complained and asked prison staff to check his property cards for mention of the stereo to prove it belonged to him. Mr K received two responses telling him that his property cards did not include mention of the stereo. Unhappy, Mr K referred his complaint to the PPO.

We looked at Mr K's property cards, and found the stereo was indeed listed among Mr K's possessions. We upheld Mr K's complaint and the prison agreed to compensate him for the missing stereo, if it could not be returned to him.

We were baffled why the complaint had not been resolved by HMPPS. Had any of the staff involved in responding to Mr K's requests and his complaints properly checked his property cards as we did, the matter could have been easily settled.

In some cases, the prison's response to a complaint simply misses the point. We know from speaking to prisoners that they place great value on prison staff communicating with them honestly and transparently. They understand that part of the rehabilitative aspect of their own prison sentence is taking responsibility for their behaviour, apologising or making amends where relevant, and committing to learning from their mistakes. It is, unsurprisingly, very important to them that those in authority are able to do the same.

In the past, we have questioned – both in our annual report and directly with HMPPS – the sincerity of apology letters written to prisoners in response to poorly handled complaints. Thankfully, the apology letters we see now are much improved. However, we still find examples of complaint handling that fail to acknowledge that the issue has arisen due to the prison's failure to act, or because of mistakes made by staff. The following case study is an example.

> "Some of the complaints we receive relate to incredibly straightforward situations, which could and should have been resolved with minimal effort by prison staff. These are frustrating for us to investigate, highlighting the waste of resource, and therefore public money, being spent resolving basic issues.

In December 2019, Ms L's brother died, and she submitted an application to attend his funeral under a Special Purpose Licence (SPL). Sadly, she missed the funeral because the prison did not consider her application in time. Ms L complained, saying that a member of chaplaincy staff had told her that they had not dealt with her application as they should have.

In the initial response, the Offender Management Hub manager simply told Ms L that she would not have been eligible for release under SPL. She said that the time frame between Ms L submitting the application and the funeral was less than seven days which meant the prison would not have completed the necessary risk assessments in time. Ms L appealed but remained dissatisfied with the reply.

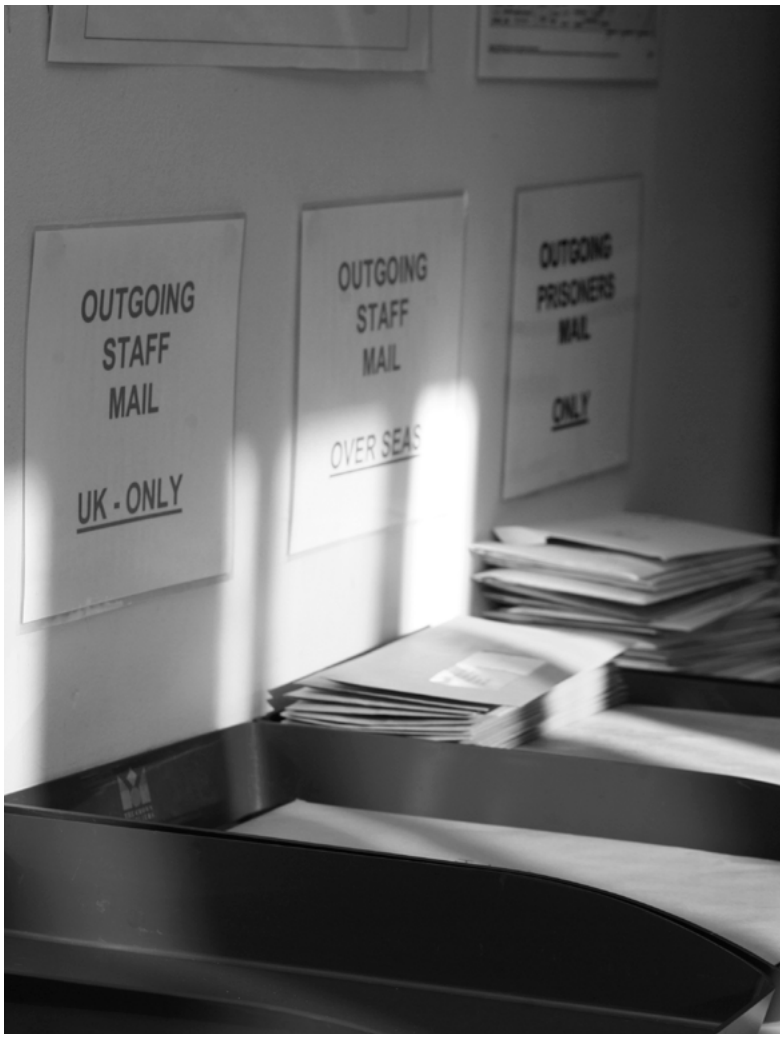
PAS contacted the PPO on Ms L's behalf. They noted that Ms L could have been released under secure escort to attend the funeral and that the relevant policy did not stipulate how long prisons needed to complete the risk assessments.

Our investigation found that an officer had delivered Ms L's application for SPL to the relevant office by hand, due to the time-sensitive nature of the application. We were disappointed that there was no trace of the application thereafter.

We noted that Ms L's brother's funeral took place 10 days after he died, and Ms L had submitted the application as soon as she was told of his death. We were also disappointed that the prison had argued that was insufficient time to carry out the necessary risk assessments for her to attend. The relevant policy makes clear that funerals can take place within 24 hours of death and that decisions about temporary release may need to be made with urgency.

We concluded that the responses to Ms L's complaints had centred on staff's view of whether she was likely to have been given permission, not the loss of the application or their failure to assess her risk in time.

We upheld Ms L's complaint and recommended HMPPS apologise to her for mishandling her application for SPL, and that staff were reminded about the processes for considering applications to attend funerals.



In some cases, while the initial HMPPS complaint responses accept responsibility for the error, a failure to follow through with remedial action results in the complainant referring the complaint to the PPO. Of course human errors occur, but these cases highlight the importance of rigorous quality assurance processes to check that things have been put right.

Mr M complained that staff had insisted he hand over Rule 39 letters for posting in unsealed envelopes, contrary to policy. The prison responded to his initial complaint and said that, while staff would not read Rule 39 post, they would 'flick through' Rule 39 letters before sealing the envelope, to check them. When Mr M appealed this response, a senior manager confirmed that prisoners could seal Rule 39 letters before placing them in the wing mailbox, provided they had marked the envelope correctly and written their name on the back. The manager said that all staff would be reminded of the correct procedures for dealing with Rule 39 post. Mr M remained unhappy and referred the complaint to the PPO.

Our investigation found that staff had, indeed, been flicking through Rule 39 post as a matter of course, contrary to the relevant HMPPS policy. We found that a Notice to staff had been issued since Mr M's complaint, but that it still instructed staff to check Rule 39 post before sealing the envelope. This was contrary to policy.

We upheld Mr M's complaint on the basis that the prison was still acting in contravention of the relevant policy and recommended that they provide us with evidence that staff had now been given the correct guidance for handling Rule 39 post. We also noted that, when responding to Mr M's complaint, the prison had said they would write a letter of apology and that this had not been done. We recommended that they do so and provide evidence of this to the PPO.

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...while the initial HMPPS complaint responses accept responsibility for the error, a failure to follow through with remedial action results in the complainant referring the complaint to the PPO.

Mr N complained that a bag of his clothing had gone missing after he gave it to an officer to deliver to the prison laundry for him. The prison refused his request for compensation, citing a disclaimer Mr N had signed that he remained responsible for his in-possession property.

Our investigation found that the relevant HMPPS policy specifically noted that prisons could not rely on such disclaimers when the prisoner had reasonably relinquished control of his property, such as when the prisoner had handed over items to be washed in the prison laundry.

We also found that Mr N had handed his bag of clothes for the laundry to an officer who said they would deliver it to the laundry. When the officer had done so, the laundry was closed and so they said that they left Mr N's property outside the locked laundry door, from where it disappeared.

We mediated this case and suggested that the prison compensate Mr N for the missing clothes that were listed on his property cards. HMPPS agreed.

Equalities

We continue to keep a watchful eye on complaints raising equality issues. We see our role in thoroughly and independently investigating such complaints as vital in holding HMPPS to account for treating people with protected characteristics fairly and equitably. Thankfully, we receive relatively few complaints that raise direct issues of equality or discrimination. That said, we acknowledge that a larger number of complaints referred to us have equalities issues at their heart.

Our analysis of the protected characteristics of those who complain to us is limited by the data gathered by HMPPS. We know that data relating to the ethnicity of people in prison, often gathered in reception as they arrive, is poor. For example, we know that prisoners from Gypsy, Roma and Traveller backgrounds are under-represented in the statistics, and we struggle to identify them among our complainants – unless the complaint is about alleged discrimination because of their ethnicity.

In 2020/21, we had hoped to publish our study on the experiences of Black, Asian and Minority Ethnic prisoners of the complaints process. Unfortunately, we have been simply unable to focus on this work due to the unexpected pressures of the pandemic. However, we remain committed to publishing the lessons we identified, both for HMPPS and for the PPO, as soon as we are able to do so.

This reporting year, we saw several complaints raising issues relating to veganism. Ethical veganism is now a protected characteristic under the Equalities Act 2010.

Mr O initially complained to the PPO because he said he was not receiving the vegan, soya-free diet which he needed for health-related issues.

We upheld the complaint and the prison agreed that he would receive the correct diet. However, Mr O wrote to us again to say that he was still being given food which contained soya and that he had submitted several complaints about this.

During the investigation, we looked at a number of Mr O's complaints. On several occasions, staff told Mr O to raise the issue directly with kitchen staff if he became aware of a problem. Eventually, a manager told Mr O that staff were doing all they could to provide him with the correct diet, that he should not make any more complaints and that, if he did, staff would not respond.

Mr O then referred another complaint to us, in which he complained that he often received cold food, and that he was not given enough to eat.

We concluded that there was considerable evidence to support Mr O's complaints, such as kitchen staff admitting that they had given him meals that were not suitable for his diet. We found that staff had apologised several times to Mr O for the ongoing problems, but at the same time had expected Mr O to continue to raise issues directly with kitchen staff in order to receive the diet to which he was entitled.

We concluded that this was inappropriate, and the prison needed to resolve the issue satisfactorily.

We were very disappointed to find that staff had discouraged Mr O from making legitimate complaints when his issues remained unresolved. We made a number of recommendations to ensure that Mr O received the correct diet, as well as recommending that the governor formally apologise to Mr O.

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The following case study highlights how policy changes can have unintended and discriminatory consequences.

Mr P complained that the prison had reduced his employment pay because he had not attained Level 1 maths. However, Mr P said that he had been diagnosed with an Autism Spectrum Disorder (ASD) and staff in the education department had told him that he would be unable to reach Level 1 maths due to his learning difficulties.

The prison initially responded that education staff had not said that Mr P could not attain Level 1 maths and so he needed to work towards it in order to receive the higher pay band. At appeal, a manager told Mr P that the local pay policy required prisoners to have gained Level 1 maths in order to receive the higher pay award. The manager advised Mr P to submit a Discrimination Incident Reporting Form about the discrimination aspect of his complaint. They also said that Mr P could ask education staff to assess whether he was able to work towards Level 1 maths, given his diagnosis. They noted, however, that the education department was currently unable to carry out face-to-face assessments due to the pandemic restrictions.

As part of our investigation, we looked at the equality impact assessment for the local pay revision policy (which introduced the two levels of pay). We found it did not include an assessment of the impact of the changes on prisoners with learning disabilities or difficulties.

We noted that Mr P had only quite recently been diagnosed with ASD, and that the diagnosis by itself did not mean Mr P could not attain Level 1 maths. We could not find any direct evidence that Mr P presented with learning difficulties, so could not say whether staff should have offered him greater support. We partially upheld the complaint. We recommended that the prison ensure Mr P's learning abilities were assessed as soon as practically possible, apply a reasonable adjustment to his pay if the assessment showed he was not able to attain Level 1 maths and conduct an impact assessment of the local pay revision policy on prisoners with learning disabilities or difficulties.

Repeat recommendations

Our 2019/21 Strategic Plan included a commitment to focus on our impact, particularly in relation to repeat recommendations. We continue to work with the services in remit to strengthen relationships. We also use the avenues available to us to highlight those issues that we repeatedly raise in our complaint investigations.

This reporting year, an ongoing concern has been how well staff complete relevant and often mandatory paperwork. For example, we have made repeated recommendations about the quality of use-of-force paperwork (including that completed by healthcare staff) and the absence of properly completed cell clearance certificates (which we often refer to in property complaints). For us, it is not always possible to conduct a satisfactory investigation into the prisoner's complaint if the relevant documents do not exist, or have not been completed to a good enough standard or without delay after the incident. If the standard of relevant paperwork causes problems for our investigations, it is difficult to see how it cannot have caused HMPPS similar problems in responding to the original complaint.

Mr Q complained that staff used unnecessary force against him and that it had amounted to assault. The Assistant Director responded that he had reviewed the available evidence and found that staff had acted appropriately in using force against Mr Q. This response was upheld at appeal and so Mr Q complained to the PPO.

We carried out a lengthy investigation, delayed by Mr Q's initial decision to pursue legal proceedings. We did not uphold Mr Q's complaint that staff used unnecessary force against him. However, we noted that, at the time, Mr Q complained he had sustained injuries during the incident. We did not find a completed Report of Injury form, or any entry in his medical record confirming that a healthcare professional had examined him after the incident.

We also found that the use-of-force documents did not contain sufficient detail to understand how the incident had unfolded and some staff did not complete the documents at all, contrary to policy. We did not uphold Mr Q's complaint but made several recommendations to improve the recording of use-of-force incidents in future. HMPPS accepted the recommendations.

In certain types of investigations, particularly involving staff behaviour or use of force, the availability of good quality CCTV or body worn video camera (BWVC) footage can be key to us concluding whether the complaint should be upheld or not. During the reporting year, we have made clear during policy consultations and discussions with senior HMPPS colleagues that we will take a robust view in cases where staff have not secured video footage and should have done, or did not turn on their BWVC when they should have. At the time of writing this report, we have been putting together our response to the new CCTV policy framework which we hope will lead to improvements in how prisons secure and retain footage vital to our investigations.

Mr R, a young person aged under 21, complained that staff used unnecessary and excessive force against him. He was unhappy with the prison's response to his complaints and so the Howard League complained on his behalf to the PPO.

As part of the investigation, we reviewed the available video footage, including that recorded on BWVC. However, we found that the footage began once Mr R was restrained on the floor of his cell and did not capture the early stages of the incident, or the moment when Mr R said that an officer punched the back of his head. As the incident took place in his cell, there was also no CCTV footage to show the preceding events. We noted that, according to policy, staff should turn on BWVC 'as soon as practicable to do so'.

We upheld Mr R's complaint. One of the recommendations we made related to ensuring that staff turn on their BWVC promptly. We concluded that, due to the circumstances of the incident, staff involved were reasonably aware that it might escalate into a confrontation and should have turned on their BWVC sooner.

Incidents resulting from the complainant's own actions

For balance, we wanted to reflect on the complaints we receive and often do not uphold, where we consider that the complainant's own actions have been central to the issue arising. Of course, in many cases, the services in remit would argue that this is the case. Our job when we investigate is to independently assess the circumstances and the appropriateness of the HMPPS complaint response.

Mr S was found guilty at adjudication of having destroyed or damaged prison property. During the adjudication, staff noted that the smoke detector in Mr S's single occupancy cell had been removed from the ceiling. In mitigation, Mr S argued that he had removed the smoke detector in the same way that an electrician would have done and that it could be reconnected. He argued that he had not therefore damaged or destroyed any prison property. He said he had removed the smoke detector because it made a ticking noise that he found very irritating.

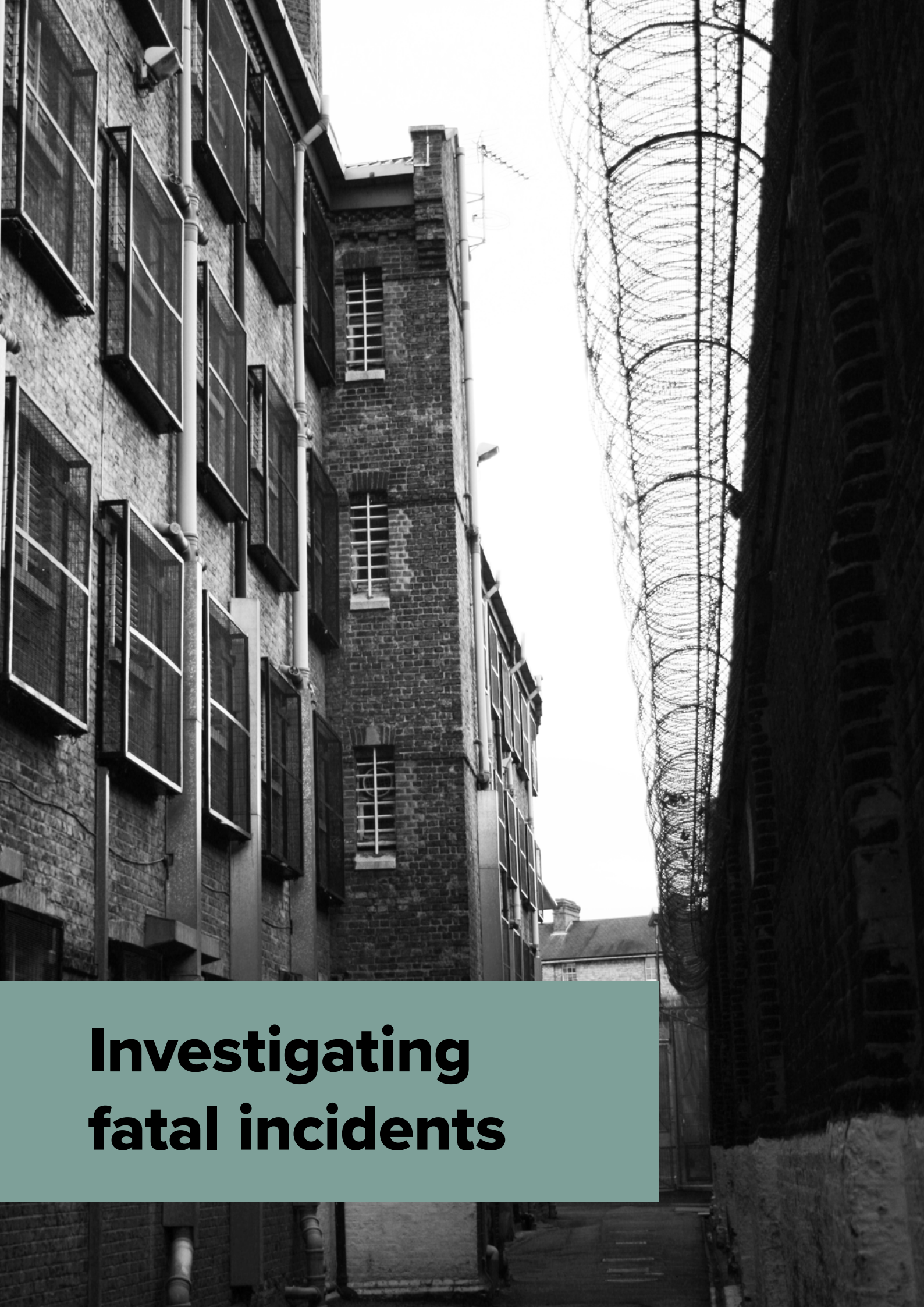
At appeal, the Prisoner Casework Unit upheld the adjudication on the basis that the offence had taken place as described and the adjudication had been conducted appropriately. The Unit noted that the maintenance department had confirmed that the smoke alarm could not be reconnected and had to be replaced, incurring a cost. Mr S was dissatisfied with this response and asked the PPO to investigate.

We concluded that, while Mr S might have believed he was not damaging the smoke detector, the fact remained that he was not qualified, nor did he have permission to tamper with the device.

The prison provided evidence that a new smoke alarm had to be fitted in Mr S's cell and confirmed that he had never previously told staff that it made a noise. We did not uphold Mr S's complaint.

Mr T asked the PPO to investigate his complaint about missing and damaged property. He said that he was forcibly removed from his cell to the segregation unit. During the incident, he said that officers threw some of his property on to the landing and other items went missing subsequently.

During our investigation, we found that Mr T had been removed from his cell to the segregation unit because he was suspected of inciting others to assault staff. We found that he had barricaded his cell using his own property, and resisted officers trying to enter the cell. We upheld the complaint. However, because we found that Mr T's own actions contributed to the damage to his property, we reduced the suggested compensation amount by 50%.



Investigating fatal incidents

COVID-19

The year was dominated by the COVID-19 pandemic which affected many different aspects of our work.

From March 2020, prisons and immigration removal centres responded swiftly to keep prisoners and detained individuals safe from COVID-19. However, although the restrictions imposed were largely successful in limiting the spread of the virus, they had a profound effect on the experiences of those in detention. Most prisoners spent around 23 hours a day in their cells, coming out only to collect meals and medication, to shower and exercise, and to socialise for brief periods with a limited number of other prisoners. Social visits from families and friends were stopped, many services were either no longer available or severely limited, and education, work and rehabilitative programmes were largely suspended.

In the case studies that follow, we make repeated references to the impact that these restrictions had on prisoners.

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Deaths from natural causes

We began investigations into 425 deaths in 2020/21, a 37% increase on last year. This was almost entirely due to the fact that there were 132 deaths related to COVID-19, making a total of 298 deaths from natural causes, 113 more than the previous year.

When we investigate deaths from natural causes, our role is primarily to consider whether the healthcare the individual received was equivalent to that he or she could have expected in the community. In doing this, we rely heavily on the clinical reviews commissioned by NHS England & NHS Improvement, and Healthcare Inspectorate Wales. We also look at a range of non-clinical issues, including whether security measures were proportionate to the risk posed by the individual, whether an application for compassionate release was made in appropriate circumstances, and whether dying prisoners and their families were treated with appropriate sensitivity and respect.

Deaths from COVID-19

Deaths from COVID-19[10] occurred in two waves. In the first wave, between 18 March 2020 and 27 May 2020[11], we were notified of and started 26 COVID-19 related fatal incident investigations. In the second wave, between 8 October 2020 and 31 March 2021, we were notified of and started 110 COVID-19 related fatal incident investigations. After this the deaths fell to very low numbers.

In the first wave, 25 of these deaths were of prisoners – and one was technically a post-release death, although the prisoner died without being released into the community. All 26 individuals had at least one underlying health condition or illness. In many cases these illnesses and health issues contributed towards their death along with COVID-19. Of the 26 deaths, the mean age was 67 years old, the youngest being 40 years old and the oldest being 90 years old. All but 2 of the 26 individuals who died were males. 22 were White British, 3 were Black, Asian or Minority Ethnic and one was White Irish.[12]

10 The PPO categorises a death as COVID-19 related if COVID-19 is listed on the death certificate or post-mortem report as either a cause of death or as a contributory factor to the death. In some cases, other underlying health issues and illnesses may also be listed as having caused or contributed to an individual's death.

11 One case was notified to us in June 2020, but the date of death was April 2020.

12 Prisons and Probation Ombudsman (2021), Learning Lessons Bulletin, COVID-19 PPO Fatal incident investigations. Looks at the first 26 deaths. We intend to publish in a further Bulletin the findings from our subsequent investigations. Available online at: **https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2021/02/6.7154_PPO_LL_Bulletin_Covid_Fatal_Incidents_WEB2.pdf**

In 2020/21 we started 132 COVID-19 investigations. As at 31 March 2021 we had issued 29 initial reports of these investigations. At the time of writing this report, we have not completed all our investigations, and we still have to investigate most of the deaths that occurred at the height of the pandemic. Consequently, our conclusions should be regarded as preliminary.

The cases we have investigated have shown the care and compassion prisoners and family members have received from prison and healthcare staff. However, we have also found some cases where care or procedures could be improved.

The SAGE EMG Transmission Group found that prisons are prone to outbreaks of COVID-19 because they are residential, crowded communal settings which are connected to the community through prison staff and new prisoners. In addition, many prisoners suffer from health inequalities and many prisoners have serious chronic health conditions.[13]

HMI Prisons found many prisons they inspected as part of the short scrutiny visits also suffer from overcrowding and this, combined with narrow landings and small offices in many cases, makes social distancing difficult.[14]

For these reasons, modelling by HMPPS and Public Health England at the beginning of the pandemic suggested that there could be 2,700 deaths in prisons if no preventative action was taken.[15] HMPPS responded by reducing inter-prison transfers, suspending social visits and introducing regime changes including the compartmentalisation strategy.[16] The total number of COVID-related deaths has been much lower than initially feared.[17]

13 **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/979807/S1166_EMG_transmission_in_prisons.pdf**

14 **https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/08/SSV-aggregate-report-web-2020.pdf**

15 Briefing paper providing an interim assessment of impact of various population management strategies in prisons in response to COVID-19 pandemic in England. Available online at: **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/882622/covid-19-population-management-strategy-prisons.pdf**

16 The compartmentalisation strategy included establishing: protective isolation units to accommodate known or probable COVID-19 cases; shielding units to protect the most clinically vulnerable prisoners with enhanced levels of bio-security and dedicated staff; and reverse cohorting units to quarantine new receptions for a period of 14 days to detect any emergent infectious cases before mixing with the general population. See briefing paper cited in footnote 15.

17 See briefing paper cited in footnote 15.

Our investigations have found that not all the prisoners who have died of COVID-19 contracted the virus in prison. Some appear to have contracted it in hospital where they had been inpatients for some time for another reason before they first showed COVID-19 symptoms.[18] In some cases, it is impossible to say where the prisoner is likely to have contracted the virus, as the case of Mr A illustrates.[19]

Mr A, who was 63, was serving an eight-year sentence for fraud. He had previously had a stroke and suffered from a number of chronic health conditions, including diabetes and asthma. He was considered to be at high risk of serious complications if he contracted COVID-19 and was therefore located in the prison's dedicated shielding unit in line with national guidance. He remained in the shielding unit after the advice to shield had ended. He applied for release from prison under the COVID-19 compassionate release on temporary licence scheme, but his application was not successful.

Eight months after the pandemic began, Mr A transferred to another prison so he could attend a court hearing. He was given a single cell in the reverse cohorting unit of the new prison. He attended court on four days. Nine days after he arrived at the new prison, he began to feel unwell and tested positive for COVID-19. His health deteriorated and he was taken to hospital where he died of COVID-19 pneumonitis.

We cannot say how, when or where Mr A contracted the infection. Given the incubation period, he could have been exposed to the virus in his original prison or his new prison, during his attendance at court, or while travelling between prisons or to and from court. The requirement for Mr A to attend court was outside the prison's control, and we were satisfied that, while in prison, Mr A's risk was managed appropriately and in line with national requirements. Staff were responsive to his reported symptoms and the subsequent deterioration in his health and he was taken to hospital promptly when he needed advanced treatment.

18 The symptoms of COVID-19 are thought to develop between 5 to 14 days after a person is infected with the virus.

19 Our investigations sometimes have to be suspended while the police complete an investigation or while we wait for the findings of the post-mortem or toxicology tests. The case studies in this report all feature investigations that we started or completed in 2020/21, although in some cases the death may have occurred in the previous year.

Where it appears that prisoners have contracted the virus in prison, it is seldom possible to say how this has happened, although we know that HMI Prisons has sometimes found that prison staff have not always observed social distancing themselves or enforced it among prisoners.

We have also seen a number of cases, like that of Mr B below, where prisoners have contracted COVID-19 after choosing not to follow advice to shield. In most cases this was because they found the additional isolation associated with shielding difficult to cope with. We have taken the view that prisoners should be free to make this choice as long as the risks have been explained to them and they have capacity to make the decision.

Mr B, who was 74, was serving a life sentence for a violent offence. His age and his chronic health conditions, including obesity, diabetes and heart disease, put him at risk of becoming seriously ill if he contracted COVID-19 and he was advised to shield. Although he initially followed the advice, he changed his mind six weeks later and disregarded any further advice to shield. In late 2020, with cases of infection increasing, he was again advised to shield. As before, he refused and, shortly afterwards, he contracted the virus. He was treated for this in prison but deteriorated very suddenly and collapsed in his cell. He was taken to hospital but died the same day.

The clinical reviewer concluded that the clinical care Mr B received was equivalent to that which he could have expected to receive in the community and said that he had been treated compassionately by competent staff at the prison. They also found that Mr B had the mental capacity to decide not to shield.

We have also investigated some cases where prisoners who have followed the advice to shield still contracted the virus, as the case of Mr C illustrates.

Mr C was 60 years old and serving a life sentence for murder. He was clinically extremely vulnerable to becoming seriously ill if he contracted COVID-19 as he was being treated for leukaemia. Due to his concern about the pandemic, Mr C gave up his job in the laundry and self-isolated before there was a requirement to shield high-risk prisoners. He did not leave his cell other than to collect his daily medication and, at the end of March 2020, he moved into the prison's designated shielding unit.

A dedicated team of four prisoners delivered meals to each cell in the shielding unit and cleaned the communal areas. Prisoners in the unit were allowed to exercise outside for 20 minutes a day, but Mr C chose not to. Despite these safeguards, Mr C became unwell at the beginning of May with symptoms of COVID-19. He was taken to hospital where he tested positive for the virus and he died about a month later in the hospital's critical care unit.

Our investigation found that Mr C had had to leave his cell in the shielding unit every day to collect his medication and, although we cannot be sure, it seems highly likely that this is how he contracted COVID-19. In addition, when the clinical reviewer visited the prison during the investigation, he observed many instances where prison officers were working and interacting socially without social distancing or PPE. We recommended that medication for prisoners at the highest risk should be dispensed safely at their cell door.

Other deaths from natural causes

In 2020/21, in addition to the 132 COVID-related deaths, we also investigated 166 deaths from other natural causes. As in previous years, in 2020/21 many of the natural cause deaths which were not COVID-19 related were of men 60 years old or over (64%) and many of these died of circulatory or respiratory system problems, or of cancer.

In almost all cases the health issues were diagnosed promptly. We also saw many examples of good end-of-life care delivered with compassion. An example is the case of Mr D.

Mr D, who was 74, was serving an Imprisonment for Public Protection (IPP) sentence[20] for threats to kill and had been in prison since 2006. He was diagnosed with bowel cancer following routine screening. As the cancer had already spread, he was not suitable for surgery and began a course of chemotherapy to slow the progress of the cancer. He was given a prognosis of 9 to 24 months. As the prison did not have 24-hour healthcare, prison and healthcare staff tried to arrange a transfer to a prison that could meet his needs better, but Mr D was adamant that he wanted to stay where he was.

20 The IPP sentence was introduced in 2005. It is composed of a punitive 'tariff' intended to be proportionate to the gravity of the crime committed and an indeterminate period which begins after the expiration of the tariff and lasts until the Parole Board (**https://www.gov.uk/government/organisations/parole-board**) judges the prisoner no longer poses a risk to the public and is fit to be released. Although the sentence was abolished in 2012, many prisoners serving such sentences remain in prison, sometimes for very long periods after the expiration of their tariff.

About two years after his diagnosis, Mr D's health began to deteriorate significantly. He was seen daily by healthcare staff who liaised with the hospital's palliative healthcare team, and advanced care plans and anticipatory medications were put in place.

Plans for transferring him to a local hospice were also discussed but Mr D said he wanted to remain in the prison. It was decided to admit Mr D to hospital overnight to put a syringe driver for pain relief in place. Mr D initially refused to go hospital but agreed to do so when a healthcare assistant (HCA) and the chaplain accompanied him in order to settle him in.

Mr D returned to the prison the following day. The Head of Healthcare had put a special 24-hour healthcare package in place so that he could die in the prison as he wished. He continued to deteriorate over the next 24 hours and was reviewed at least every two hours by healthcare staff. He appeared pain-free and relaxed. During the day, the HCA sat with him and talked to him constantly "to make sure he knew he was not by himself". The HCA, a nurse and a prison officer were with him when he died.

We agreed with the clinical reviewer that Mr D received compassionate patient-centred care and that this was an example of excellent practice.

However, by no means all prisoners receive care of this quality, as the following case study illustrates.

Mr E, who was 38, was a Category A prisoner[21] serving a life sentence for sexual offences in a high security prison.

He had little contact with healthcare services until two days before he died when he told staff that he was suffering with abdominal pain and vomiting. His urine sample contained high levels of glucose and ketones, a sign of diabetic ketoacidosis, although Mr E had never been diagnosed with diabetes. A nurse called a hospital doctor for advice, who said Mr E should be sent to hospital for further assessment. Mr E remained under observation in the prison's healthcare centre for almost seven hours while discussions took place with prison staff about arrangements for sending him to hospital.

Mr E died in hospital two days later of diabetic ketoacidosis. The pathologist noted that it appeared to be a new diagnosis of Type 1 diabetes (a chronic condition where the pancreas produces little or no insulin) and said that it is not uncommon for someone of Mr E's age to develop Type 1 diabetes.

21 Category A prisoners are those whose escape would be highly dangerous to the public or national security.

We were concerned about the long delay in arranging Mr E's transfer to hospital. We recognised that he was a Category A prisoner and that his transfer to hospital therefore required careful consideration. However, much of the delay was caused by a breakdown in communication between prison and healthcare staff, and between members of the healthcare team. Important decisions taken about the timing of Mr E's transfer to hospital were not recorded and there was confusion about what had been agreed. Healthcare staff also failed to escalate their concerns about the delay to senior managers. We were unable to say if the outcome might have been different for Mr E if he had been sent to hospital earlier.

We were also concerned that the prison did not tell Mr E's family that he was seriously ill in hospital until the early hours of the day he died.

Restraints

When prisoners have to travel outside prison, for example to attend hospital, a risk assessment is conducted to decide the level of the security arrangements required, including restraints. The prison service has a duty to protect the public, but this has to be balanced with a responsibility to treat prisoners with humanity. Case law on this issue is clear following a judgement in the High Court: the use of handcuffs on a prisoner who is receiving medical treatment or care must be necessary and proportionate, taking into account factors such as the prisoner's current health and mobility.[22]

Unfortunately, we continued to see far too many cases in which very elderly, frail and/or very unwell prisoners with limited mobility were escorted to hospital in handcuffs – and some remained restrained until shortly before they died. This is uncomfortable and undignified for prisoners and upsetting for their families. The PPO has been saying for years that it is simply unacceptable that such inhumane practices are allowed to continue. We repeat that the leadership of the prison service should reflect on why some establishments are able to address this issue successfully while others seem unable to do so.

The case of Mr F illustrates our concerns and also provides a wider example of poor healthcare.

22 R (on the application of Graham) v Secretary of State for Justice [2007] All ER (D) 383 (Nov) (23 November 2007, Queen's Bench Division, Administrative Court, Mitting J)

Mr F, who was 87, had received a 27-month sentence for causing death by dangerous driving. When he arrived in prison, Mr F was referred to the prison GP for a review of his complex medical needs, including a hip injury that incurred two weeks earlier that affected his mobility and for which he was on strong painkillers. The GP stopped Mr F's pain relief prescription in favour of a less effective medication that she considered would put him at less risk of bullying in prison. She also cancelled an outstanding hospital appointment for security reasons, because Mr F knew the date and time of the appointment.

The following day, Mr F fell and hurt his hip. A nurse examined him and concluded that he had not fractured his hip. He was transferred to the prison's inpatient unit to manage his needs better. A week after his fall, Mr F complained of severe pain and a prison GP prescribed pain relief. When the pain continued the following day, he was taken to hospital for urgent assessment. He was restrained with an escort chain until the afternoon of the following day, when all restraints were removed. He was diagnosed with a hip fracture and died in hospital of heart disease, 10 days after he had first arrived in prison.

Given Mr F's age, frailty and medical conditions, it was always going to be a challenge to manage him safely in prison. However, the clinical reviewer concluded that Mr F's care fell below the standard of care he could have expected to receive in the community. She found, among other things, that:

- Mr F's pain was not well managed. The decision to stop his pain relief prescription when he arrived in prison was incorrect and should have been reviewed when he moved to the prison's inpatient unit. It was only after the extensive efforts of an individual nurse that effective pain relief was finally reinstated when Mr F had become bedbound a week later.
- There was no care plan to manage Mr F's complex medical and social care needs.
- The prison GP cancelled an outstanding hospital appointment without arranging for a manager to risk assess whether it could go ahead and took no action to arrange for the appointment to be re-booked.
- The examination of Mr F's hip after his fall was full and appropriate, but the conclusion that he had not broken his hip should have been revisited when his pain continued.

Although we commended some individual members of staff for the care they showed to Mr F, we shared the clinical reviewer's concern that the investigation had uncovered a number of issues about the capacity and capability of the prison's healthcare team. In light of the findings of our investigation, we recommended that the governor and the NHS England & NHS Improvement Regional Healthcare Commissioner should satisfy themselves that the healthcare provision at the prison is adequate for the needs of the population.

We were also concerned that Mr F was restrained with an escort chain when he was taken to hospital and that he remained restrained for 15 hours. Four hours elapsed between the decision to send Mr F to hospital and the ambulance arriving to take him. We consider that this was adequate time for the prison to have completed a full risk assessment and ensured that any restraints used were commensurate to the risk posed by a frail 87-year-old man who was in severe pain and unable to walk, and accompanied by two prison officers. Instead, the prison used an emergency risk assessment that did not allow for Mr F's deteriorating physical health and mobility to be considered. We considered that this was unacceptable.

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Self-inflicted deaths

At the beginning of the pandemic, many observers thought there might be an increase in self-inflicted deaths as prisoners struggled to cope with the very restricted COVID-19 regime and the long periods locked in their cells. This did not happen initially and, in fact, self-inflicted deaths dropped to unprecedentedly low levels in September 2020 and October 2020. However, the number of self-inflicted deaths began to rise in November 2020 and remained high for the last four months of 2020/21. Over the year as a whole, there were 85 self-inflicted deaths, 1 more than last year.

The concerns we identified in our investigations remained the same as in previous years, although a particular theme during the pandemic has been the lack of staff contact with prisoners, which we discuss in this section.

Early days

The early days and weeks of custody are often a difficult time for prisoners and are a period of particular vulnerability for those at risk of suicide.[23] The prison service has introduced reception, first night and induction processes to help identify and reduce this risk. Some prisoners have obvious factors, such as mental ill-health or a lack of experience of prison, that indicate they are at heightened risk of suicide, but our investigations too often find that staff have failed to recognise or act on them. We recognise that prison staff have a hugely demanding task. Reception, first night and induction facilities, particularly in large local prisons, are busy places that have to manage large numbers of prisoners, many of whom have multiple risks and vulnerabilities. We also understand that risk assessment must always rely in large part on staff judgment.

However, to be effective, risk assessment must take account of known or readily available information associated with suicide. As we have noted many times in individual investigation reports, thematic reports and annual reports, too often staff in prison receptions make decisions based on their perceptions of a prisoner's presentation or the prisoner's assurances that they have no thoughts of suicide or self-harm. Known risk factors which might increase the prisoner's risk, such as a history of suicidal behaviour, or the circumstances of their offence, can often be overlooked.

23 Prisons and Probation Ombudsman (2016), Learning Lessons Bulletin, Early days and weeks in custody. Available online at: **https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2016/02/PPO-LearningLessons-Bulletin-Fatal-incidents-issue-10-early-days-and-weeks-in-custody_Final_digital-1.pdf**

Our investigations into deaths in the early weeks of custody frequently uncover failures to identify risk factors, and therefore to begin prison service suicide and self-harm monitoring and support procedures (known as ACCT).[24] The case of Mr G demonstrates the importance of assessing risk appropriately from the beginning.

Mr G, who was 44, was remanded into prison custody charged with the murder of his partner. He had several recognised risk factors for suicide and self-harm, including an offence of violence against a close family member, a history of depression and two serious incidents of self-harm in the past month. We were very concerned that, despite this, staff did not start ACCT procedures and instead relied on the fact that Mr G said he had no thoughts of suicide or self-harm and that he maintained good eye contact.

The following morning, Mr G attended a court hearing by video link, and prison managers decided that Mr G should be managed under ACCT procedures – although there is no evidence that anyone spoke to Mr G about this. Mr G returned from his court appearance and was locked in his cell. 45 minutes later, an officer went to conduct the first ACCT observation and found Mr G hanging in his cell.

He cut Mr G down and an ambulance was called immediately, but Mr G could not be resuscitated and was pronounced dead 18 hours after he arrived at the prison.

We were particularly concerned that this was the fifth investigation in the previous two years in which we had expressed concerns about the prison's failure to identify those at risk of suicide and self-harm when they arrive. We escalated these concerns to the Prison Group Director responsible for the prison.

24 Assessment, Care in Custody and Teamwork. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody). A similar system, known as Assessment, Care in Detention and Teamwork (ACDT), is used in immigration removal centres.

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Mental health

The case of Mr H shows that sound risk assessment continues to be important throughout a prisoner’s time in prison, and also illustrates the role that unmet mental health needs may play in increasing a prisoner’s risk of suicide.

Mr H, who was 34, was on remand charged with trespass and theft. He had a history of substance misuse, depression and self-harm. When he arrived in prison, he was put on a methadone (opiate substitute) programme and referred to the mental health team.

Over the next few months, Mr H gave staff no cause for concern except on two occasions when he was asked to share a cell and reacted aggressively. He sometimes said he wanted to see someone from the mental health team but would not explain why. A further mental health referral was made. His mental health assessment was postponed twice because the mental health nurse was too busy to see him and then postponed again because of COVID-19 restrictions.

The day before he died, Mr H again reacted aggressively when asked to share a cell. Later that day, he was found with a kettle cord wrapped round his neck. He said he could not cope with sharing a cell and wanted to die. Staff opened ACCT procedures with two observations an hour. Two hours later, he was found with a ligature made from a bed sheet round his neck and attached to the bed. He was moved to a safer cell[25] and his observations were increased to four an hour. Another mental health referral was made.

The following morning, Mr H again said that he did not want a cellmate and wanted to be dead. At the ACCT review later that morning, Mr H was told he would not have to share a cell and he denied any thoughts of suicide or self-harm. His risk was assessed as low and ACCT observations were reduced to two an hour. He was moved out of the safer cell and back to a standard cell.

That afternoon, he was found hanging in his cell. He was taken to hospital but died shortly after arrival. We were concerned that staff failed to properly assess Mr H's risk of suicide and reduced his observations and moved him from the safer cell too quickly.

The clinical reviewer also found that the standard of mental health care Mr H received was not equivalent to that he could have expected to receive in the community. A nurse made a mental health referral for Mr H when he first arrived but, despite repeated requests, this had not taken place by the time he died six months later. Regardless of the COVID-19 restrictions, this was unacceptable. Also, despite Mr H's medical records showing that he was prescribed an antidepressant in the community, this was overlooked by prison healthcare staff and his prescription was not continued in prison.

25 Safer cells are designed to minimise ligature points.

Lack of staff contact

In 2018, HMPPS introduced the Offender Management in Custody model. This requires all prisoners in the male closed estate to have a dedicated prison officer key worker. Governors are required to ensure that key workers are allocated an average of 45 minutes per prisoner per week to deliver the key worker role, which must include spending individual time with each prisoner. The aim is to reduce violence and self-harm in prisons by developing better relationships between staff and prisoners. The key worker scheme was gradually rolled out across the prison estate and we welcomed it as a very positive development. Before the pandemic we had started to see examples of the ways in which key workers were able to identify prisoners' concerns and help put support in place for them.

Unfortunately, the key worker scheme was suspended across the prison estate as a result of the COVID-19 restrictions, although prisons were advised to put special alternative arrangements in place for vulnerable prisoners who would benefit from extra support during the lockdown.

In the absence of a universal key worker scheme, a recurring theme in many of our investigations during the pandemic has been a lack of meaningful contact between staff and prisoners. With prisoners spending long periods in their cells, staff have significantly fewer opportunities than they had pre-pandemic to talk to them informally and to observe them interacting with their peers.

As a result, we have seen a number of cases where staff have not picked up that a prisoner's mental or physical health is deteriorating or that they are taking drugs, being bullied, or having relationship problems. An example is the case of Mr I.

Mr I, who was 29, was sentenced to two and a half years in prison for a violent offence. He had been released on licence but was recalled to prison just before the first COVID-19 lockdown began in March 2020.

Mr I had a long history of mental health issues, substance misuse and self-harm. The prison's mental health team prescribed medication to treat his symptoms of depression and anxiety.

About a month after he arrived at the prison, he told a mental health nurse during a telephone review that spending so long locked in his cell was causing him to hear voices and have thoughts of self-harm. Mr I's mother raised concerns with prison staff that he had accumulated drug debts, but Mr I did not tell staff about this and staff saw no evidence that he had misused illicit substances, was in debt or was being bullied.

Seven weeks after he had arrived at the prison, Mr I was found hanged in his cell. Post-mortem toxicology results identified that he had taken psychoactive substances (PS) before he died.

We were concerned that, despite his risk factors, Mr I was not identified as someone who needed extra support and who would have benefitted from additional meaningful contact with staff during the pandemic through special key work arrangements. This was a missed opportunity to identify that he was struggling to cope, was using drugs and may have been the victim of bullying.

The COVID-19 restrictions also meant that Mr I's only contact with mental health staff was conducted over the telephone by a nurse who had never met him in person. We were also concerned that when he told the nurse that he was having thoughts of self-harm three weeks before his death, she did not start ACCT procedures and did not share this important information with prison staff.

Emergency response

A frequent theme in our investigations into self-inflicted deaths is the inadequacy of the emergency response by staff. There are several elements to this: staff may not enter the cell quickly enough when a prisoner is unresponsive; they may not call an emergency medical code quickly enough; the control room may not call an ambulance promptly in response to an emergency code; ambulances may be delayed because staff fail to provide sufficient information about the emergency or to facilitate access to the prison; and staff may fail to begin resuscitation promptly. Similar issues can also arise in the case of drug-related deaths and deaths from heart attacks and other natural causes. The following case study is an example of what can go wrong.

Mr J, who was 40, was three years into a life sentence for aggravated burglary and robbery. He had a history of depression and drug misuse. Our investigation found a number of failings in Mr J's care. Although he told staff that he was under threat, there is no evidence that his fears were investigated, and we were also concerned that there was very little evidence of any meaningful staff interaction with him, which could have been a missed opportunity to identify his fears and assess his risk to himself.

When the night patrol officer came on duty on the night of Mr J's death, he found that Mr J had blocked the observation panel of his cell door. He said he told Mr J to remove the obstruction at about 8.30pm. When the officer checked again shortly before 6.00am, the panel was still blocked and Mr J did not answer when the officer called his name. Although another officer was also present, they did not contact the night manager for over an hour. When the night manager and other officers eventually opened the cell door, they found Mr J hanged in the cell. It was clear that he had been dead for some time.

We were very concerned that staff took no action for over 10 hours to ensure that Mr J unblocked the obstruction, even when they were unable to obtain a response from him, contrary to national instructions. We cannot say if this affected the outcome for Mr J, but at the very least he would have been found earlier. We recommended that the governor consider whether disciplinary charges should be brought against the officers concerned.

Drug-related deaths

It might have been hoped that the suspension of social visits and the very restricted COVID-19 regime would have reduced the opportunities for smuggling drugs into prison and the illicit trading of prescription drugs within prison. We might therefore have expected to see a reduction in the number of drug-related deaths. Unfortunately, this does not seem to have been the case. In 2020/21, we began investigations into 30 other non-natural deaths (most of which are drug-related deaths), which is 8 fewer than last year.[26] However, there are still 11 deaths awaiting classification, and we know from experience that most of these will turn out to be drug-related deaths. If so, the total number of drug-related deaths in 2020/21 is likely to be similar to or even slightly higher than last year.

As the following case studies show, we have continued to see deaths involving all kinds of drugs, including opiates, PS and prescription drugs.

Mr K, who was 26, was serving a sentence of two years and four months for burglary and assault. He had a history of heroin misuse in the community and, when he entered prison, he was put onto a detoxification programme with a gradually decreasing dose of methadone.

Although Mr K successfully reduced his prescribed dose of methadone during his five months in prison, he was repeatedly found under the influence of PS and cannabis. He was referred to the substance misuse team but refused to engage with them. He was found dead in his cell one morning.

The post-mortem found that Mr K's death was due to inhaling vomit as a result of heroin use. There was nothing to suggest that Mr K had used heroin in prison before this. Tolerance to heroin can diminish very quickly after even a few days' abstinence, increasing the risk of an overdose, and it appears that Mr K's tolerance had diminished as a result of five months' abstinence.

26 Please see the About the data section for more details and definitions. Most other non-natural deaths are drug related.

The case of Mr L illustrates the dangers posed by PS to even apparently fit young men.

Mr L, who was 28, was serving a four-year sentence for robbery and driving offences. He had regularly misused alcohol, cannabis and cocaine in the community. He also had a history of mental health issues, including depression and psychosis.

In the months before his death, prison and healthcare staff suspected that Mr L had used drugs on several occasions. Healthcare staff treated Mr L appropriately and regularly warned him about the risks of using PS and the negative effect it could have on his mental health. The day before his death, a nurse noted that Mr L appeared to be under the influence of an illicit substance and refused to give him his evening medication because of the risk of mixing it with illicit drugs. The following day, two substance misuse workers saw Mr L and warned him again about the risks of using PS.

That afternoon Mr L was found dead in his cell with drug-smoking paraphernalia in his hand. The post-mortem found that Mr L had died from the toxic effects of PS and an undiagnosed heart condition.

The clinical reviewer was satisfied that the substance misuse care that Mr L received was equivalent to that which he could have expected to receive in the community. She was also satisfied that there had been no signs that Mr L had any heart issues before he died. She considered that Mr L's mental health care was of a particularly good standard, as he was under the care of a consultant psychiatrist and his named community psychiatric nurse regularly visited and reviewed him.

The case of Mr M illustrates the potential dangers of prescription drugs and the need to keep prescribing under review and to minimise opportunities for prisoners to trade such drugs illicitly.

Mr M, who was 55, was serving a four-year sentence for burglary, fraud and theft. He had a history of drug abuse in the community and was placed on a methadone replacement programme in prison. He was located on an incentivised substance-free living (ISFL) wing, where prisoners are given privileges in exchange for agreeing to stay drug-free.

Mr M was diagnosed with a compressed nerve in his spine and he frequently complained of pain in his arm, back and leg. Prison GPs prescribed a range of pain relief medication and, over a period of about 15 months, they repeatedly increased the dose when Mr M continued to complain of pain.

Some months before he died, Mr M told a prison GP that he was buying prescription pain killers from other prisoners, but the GP did not tell prison staff or the substance misuse team and continued prescribing pain relief.

One morning Mr M was found dead in his cell. The post-mortem found that he had died from a combination of six different prescription drugs.

All but two of the prescription drugs found in Mr M's system had been prescribed to him. The clinical reviewer was concerned at the high dosage of central nervous system depressants (drugs that slow breathing) prescribed to Mr M and noted that one of the drugs prescribed was not advocated for long-term use in prison. We shared the clinical reviewer's concern that, despite the known risks of prescribing that combination of drugs, no one ever carried out a medication review.

We were also very concerned that the GP did not tell wing staff or the substance misuse team that Mr M was buying painkillers from other prisoners, although this was a clear breach of the agreement Mr M had signed to remain drug-free on the ISFL wing and put him at risk, given he was taking them alongside his prescribed methadone.

As well as killing prisoners directly, drugs also contribute indirectly to many self-inflicted deaths because of the effect they can have on mental health and their close association with debt and bullying. Our investigations have repeatedly shown that prisoners are able to access drugs with apparent ease in many establishments, despite the COVID-19 lockdown. We appreciate the difficulties, but it is clear that many prisons need to do more to disrupt the supply of drugs.

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Homicides

There was 1 homicide in 2020/21, compared to 2 the previous year. We have suspended our investigation until the police investigation has been completed.

Women

We started 10 fatal incident investigations of female prisoners in 2020/21, compared to 6 in the previous year and 12 in 2018/19. Of these deaths, 8 were from natural causes (including 5 from COVID-19) and 2 were self-inflicted (including the apparent suicide of an 18-year-old, which we are still investigating at the time of writing this report). We also investigated the death of a woman who died in hospital some months after attempting to hang herself. This was technically a post-release death, although the woman was never released into the community.

Our investigations into the deaths of women prisoners generally identify similar issues to those of men. In the case of Ms N, for example, there were concerns about the quality of the healthcare she received.

Ms N, who was 46, was serving a long prison sentence for sexual offences. She had had a kidney transplant three years previously and entered prison a few weeks after that. She remained in reasonable health until about four months before she died, when her body appeared to reject the transplanted kidney. A month later she became very unwell and was taken to hospital by emergency ambulance with suspected sepsis. She remained in hospital, released on temporary licence, and died two months later of necrotizing pancreatitis and COVID-19.

The clinical reviewer found that prison healthcare staff had liaised effectively with hospital staff to ensure that Ms N received continuity of care following her kidney transplant, and that she attended routine follow-up appointments with a renal consultant. However, the clinical reviewer concluded that when Ms N's health deteriorated, healthcare staff missed several opportunities to identify concerns which should have resulted in earlier clinical intervention. In that respect, her healthcare was not equivalent to that which she could have expected to receive in the community.

We noted that Ms N only tested positive for COVID-19 at the very end of her life. Given the time she had been in hospital, it seems likely that she had contracted the virus there.

Ms O's death shows that prisoners at risk of suicide will not always choose to reveal their distress to staff.

Ms O, who was 46, was 4 years into a 10-year prison sentence for a violent offence. She had a history of substance misuse, including heroin and crack cocaine, and had harmed herself in the community. However, she engaged with substance misuse services in prison and completed a number of rehabilitative courses. There were no significant self-harm incidents.

About six months before her death, Ms O transferred to an open prison where she settled well. A few months after her arrival, she attended a prisoner-led support group designed to give prisoners strategies for coping with past trauma. After a few sessions, Ms O stopped going and told prison officers that the group had stirred up difficult memories for her about historic abuse. Ms O said she did not want mental health support and also refused substance misuse support. She subsequently told her substance misuse worker that going to prison had saved her life and that she had not used illicit drugs in three and a half years.

A week before her death, Ms O was told that a former partner was seriously ill. Two days later, she learned that her step-sister had died. She assured staff that she was fine and had no thoughts of suicide or self-harm. However, staff started ACCT procedures a few days later after Ms O told an officer that she was having suicidal thoughts. Staff checked her at least once per hour. Ms O said that she felt low but had no thoughts of harming herself and she wanted the ACCT to be closed because she said being checked at night disrupted her sleep. Despite this, staff kept the ACCT in place with hourly checks. On the morning of her death, Ms O told staff that she was "okay". Later that morning, staff found Ms O hanged in her cell.

We were satisfied that Ms O was offered appropriate support when she said that the prisoner-led trauma group had stirred up some difficult memories, and that staff appropriately opened ACCT procedures after the death of her step-sister. Despite her assurances that she was not at risk of suicide, staff left the protective measures in place. We do not consider that there was more they could have done to prevent her death.

We were, however, concerned that although the prisoner-led group had the potential to stir up painful memories and feelings, there was no structure in place to support the women who attended it. We recommended that the Executive Director for the Women's Estate should satisfy himself that this prisoner-led work is appropriate for delivery in prisons and, if it is, that groups are properly monitored and supported.

Under 21s

Three young people aged under 21 died in prisons and young offender institutions (YOIs) in 2020/21 (compared to 4 the year before). All the deaths were self-inflicted. Two are still being investigated at the time of writing this report, and the third is described in the following case study.

Mr P, who was 19, was nearly two years into a life sentence for murder. He was located in the same YOI as his older brother and the two were described as "inseparable". He was prescribed medication for anxiety but apparently got on well with the other young offenders.

Because Mr P was serving a long sentence, it was necessary to transfer him to a YOI with the facilities to support his progression through his sentence. For security reasons, it is standard practice not to tell prisoners of an impending transfer until the morning of the transfer.

About two weeks before his death, Mr P was told that he would be transferring to another YOI that day. He was very upset and said that he would harm himself or take an overdose if he was forced to move. He then barricaded his cell. After removing the barricade, staff let Mr P's brother speak to him, after which Mr P agreed to transfer. Mr P's brother was allowed to pack his belongings for him and to go to reception to say goodbye.

The prison told us that they had originally intended that Mr P's brother would transfer to the same YOI, but this was not possible as he was very close to his 21st birthday, at which point he would need to transfer to an adult prison. We were not convinced that a solution could not have been found to allow the brothers to have stayed together.

When he arrived at the new YOI, Mr P was placed in the reverse cohorting (quarantine) unit for 14 days because of the COVID-19 restrictions. He was allowed to leave his cell each day for exercise, but often chose not to. Staff recorded that they were concerned that Mr P might be vulnerable or a potential target for gangs when his quarantine period ended. They also recorded that he was reluctant to mix with other young offenders and panicked at the thought of it. He was referred to the safer custody team and the mental health team and a prison GP prescribed him an antidepressant.

At the end of the two-week quarantine period, Mr P was able to socialise with the general population for the first time. However, he did not leave his cell at all on the first day and did not collect his medication or his lunch, take a shower, go out for exercise or socialise. He was found hanged in his cell in the early hours of the following morning.

We had many concerns about Mr P's care. Some positive, supportive action was taken at his previous YOI when Mr P said he would kill himself if he had to transfer. However, we were very concerned that no one considered whether it would be appropriate to start ACCT procedures and that Mr P's distress about the transfer was not fully communicated to his new YOI. We were also concerned that, although staff at the new YOI had expressed concerns about his potential vulnerability, no prison staff had any meaningful contact with Mr P on the day before he was found dead and no one identified that his failure to leave his cell all day might indicate an increased risk of suicide and self-harm.

Individuals detained under immigration powers

There was a death in an immigration removal centre in 2020/21, an apparently self-inflicted death which we are still investigating at the time of writing this report. We also investigate the deaths of detained individuals held in prisons who experience the same uncertainties about their future, as the following case illustrates.

Mr Q, a 50-year old Polish national, was sentenced to eight months in prison for causing death by careless driving. It was his first time in prison. He was served with a deportation order and was due to return to Poland when he was halfway through his sentence. Mr Q was happy with this. However, due to the COVID-19 pandemic, the Home Office was unable to arrange flights to Poland and Mr Q continued to be detained in prison under immigration powers beyond the half-way point, pending his deportation.

Mr Q's family and the Polish Embassy contacted the prison with concerns about the effect Mr Q's continued detention was having on his mental health. A safer custody manager said that Mr Q would be referred to the prison's mental health team, but this did not happen.

Five attempts were made to deport Mr Q to Poland, but the flights were cancelled each time due to the COVID-19 pandemic. The day after the last attempt, Mr Q was found unconscious in his cell. He had used a belt to strangle himself. He was taken to hospital but never regained consciousness and died three days later.

The reasons for Mr Q's continued detention were outside the prison's control. However, we were very concerned that prison staff did not do more to keep him informed of the situation and to check on his welfare, especially as he spent long periods locked in his cell because of the COVID-19 restrictions. When Mr Q's family raised concerns about Mr Q's mental health, staff failed to check on his welfare or make a referral to the mental health team.

We were also concerned that, although Mr Q spoke very little English, staff rarely used interpretation services to communicate with him. We considered that this would have made it difficult for staff to identify his distress.

Approved premises

We began investigations into the deaths of 15 residents of probation approved premises (APs)[27] in 2020/21, 2 fewer than last year. Of these deaths, 9 were other non-natural,[28] 4 were self-inflicted and 2 were from natural causes (including one COVID-19 related death).

We continue to be concerned at the number of drug-related deaths among AP residents. There is a high prevalence of people with substance misuse issues in prisons[29] and, as most AP residents have been released from prison on licence, substance misuse is one of the key issues AP staff must manage.[30]

As we said in a Learning Lessons Bulletin[31] published in 2017, the risk of mortality for those who have just left prison is significantly higher than mortality in the general population, and this risk is especially stark in relation to substance misuse. There is a high risk of overdose in the first month after release; the first few days after release is the peak period.[32] This may be due to changes in individual tolerance for opiates, which can decrease in a matter of days after a period of abstinence, and/or a lack of understanding of the strength of the illicit substances which may be available in the community. The risk of overdose is particularly acute when the resident has undertaken a detoxification programme in prison.

27 Approved premises (formerly known as probation and bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. APs are staffed 24 hours a day and provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment to reduce the likelihood of further offending and manage risk. Residents are subject to curfew restrictions and are required to be at the AP overnight. The exact nature of the provision varies from AP to AP, but they will all offer one-to-one or group work to deliver accredited programmes, have curfew monitoring, require residents to sign in, and have drug and alcohol testing availability.

28 Please see the About the data section for more details and definitions. Most other non-natural deaths are drug related.

29 The Centre of Social Justice (2015), Drugs in Prisons, London: The Centre of Social Justice. Available online at: **https://www.centreforsocialjustice.org.uk/core/wp-content/uploads/2016/08/CSJJ3090_Drugs_in_Prison.pdf**

30 Her Majesty's Inspectorate of Probation (2017), Probation Hostels (Approved Premises) Contribution to Public Protection, Rehabilitation and Resettlement, Manchester. Available online at: **https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2017/07/Probation-Hostels-2017-report.pdf**

31 Prisons and Probation Ombudsman (2017), Learning Lessons Bulletin, Approved Premises – substance misuse. Available online at: **https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2017/11/PPO-Learning-Lessons-Bulletin_AP-deaths-substance-misuse_WEB.pdf**

32 Phillips, J., Gelsthorpe, L., Padfield, N. and Buckingham, S. (2016) Non-natural deaths following prison and police custody, Research report 106. London: Equality and Human Rights Commission. Available online at: **https://www.equalityhumanrights.com/sites/default/files/research-report-106-non-natural-deaths-following-prison-and-police-custody.pdf**

In previous years, we have recommended that the National Probation Service should update its drugs strategy to include the provision of naloxone[33] (an opiate antidote) in all APs and the introduction of testing for PS. We are therefore very pleased that naloxone is now being rolled out to all APs, and we will continue to monitor this. We continue to recommend that PS testing should be made available in APs as soon as possible.

Although a lot of good work is done in APs, some of the cases we investigated showed insufficient focus by some AP staff on the risk of relapse and overdose, as the following case study illustrates.

Mr R, who was 39, was serving an 18-month sentence for common assault and grievous bodily harm. After nine months in prison, he was released on licence to an AP. Mr R had a history of substance misuse but had engaged with substance misuse services in prison and was alcohol and drug free when he was released.

A few days after arriving at the AP, Mr R told a probation worker that he had taken a photograph of an AP resident who was "off his head" on drugs and that the AP staff had taken no action. He said he was concerned about the level of drug use at the AP and wanted to move elsewhere. However, he remained at the AP.

A week later, during a routine check, AP staff found Mr R on his bed covered in vomit. They checked on him through the night but took no further action. A fortnight later, Mr R missed his evening curfew and, when he returned to the AP later that night, he appeared to be under the influence of drugs. Staff monitored him overnight but took no further action.

A few days later, during a late-night welfare check, staff found Mr R collapsed in a bathroom. They called for an ambulance and Mr R was taken to hospital. He died three days later from the toxic effects of PS.

We were very concerned that drug use appeared to be widespread at the AP and that there was no evidence that staff were taking action to address this. We were also concerned that AP staff did not report Mr R's incidents of suspected drug use to his offender manager.

At the time Mr R was at the AP, there was no drug testing of residents. Although a new AP manager took up post on 7 September and reintroduced drug testing soon afterwards, AP staff are still not able to test for PS. We have flagged this as an issue in several previous AP deaths and repeated our recommendation about the need for PS testing in APs.

33 Naloxone is an emergency medication that can reverse the effects of an overdose of opioids like heroin or methadone. It can save someone's life if it is used quickly. It is a prescription-only medicine, but drug services can supply it without a prescription, and anyone can use it to save a life in an emergency.

Discretionary investigations

During the year, we conducted 2 discretionary investigations commissioned by the Secretary of State for Justice: a death of a newborn baby in a prison cell in September 2019, and a stillbirth in prison in June 2020. We have identified lessons about the care of pregnant prisoners who either refuse to engage with healthcare or who choose not to disclose their pregnancy. Both reports will be published on our website as soon as possible.

Appendices

Recommendations

Our vision is that the PPO's independent investigations should contribute to making custody and offender supervision safer and fairer. A vital part of fulfilling this ambition involves making effective recommendations for improvement in both complaint and fatal incident investigations. Our recommendations must be specific, measurable, realistic and time-bound and must focus on outcomes to deliver the required changes needed to reduce the likelihood of repeat failings.

When we make recommendations in a fatal incident investigation, the service in remit must confirm where a recommendation is accepted and produce an action plan outlining what action will be taken and when, and who will be responsible for the action.

For complaints, the organisation must confirm whether they accept any recommendations and must provide evidence of implementation.

Where the service in remit does not accept a recommendation, for public sector prisons the Director General of Prisons must notify the PPO. For other services in remit, and for privately managed prisons, a designated senior manager must respond.

The PPO has agreed a feedback loop with HMI Prisons to support independent assessment of what prisons have done to implement our recommendations. As part of their inspections, HMI Prisons follow up the recommendations we make following fatal incident investigations. They also invite PPO complaint investigators to identify any particular issues they wish to raise about a prison prior to the inspection.

Our investigations provide an opportunity to understand what has happened and to correct injustices. Recommendations also enable us to identify learning for organisations, including sometimes at national level. Disappointingly, we continue to identify repeat concerns and failings and to make the same recommendations, sometimes in the same establishments, and sometimes after the recommendations have been accepted and action plans agreed to implement them.

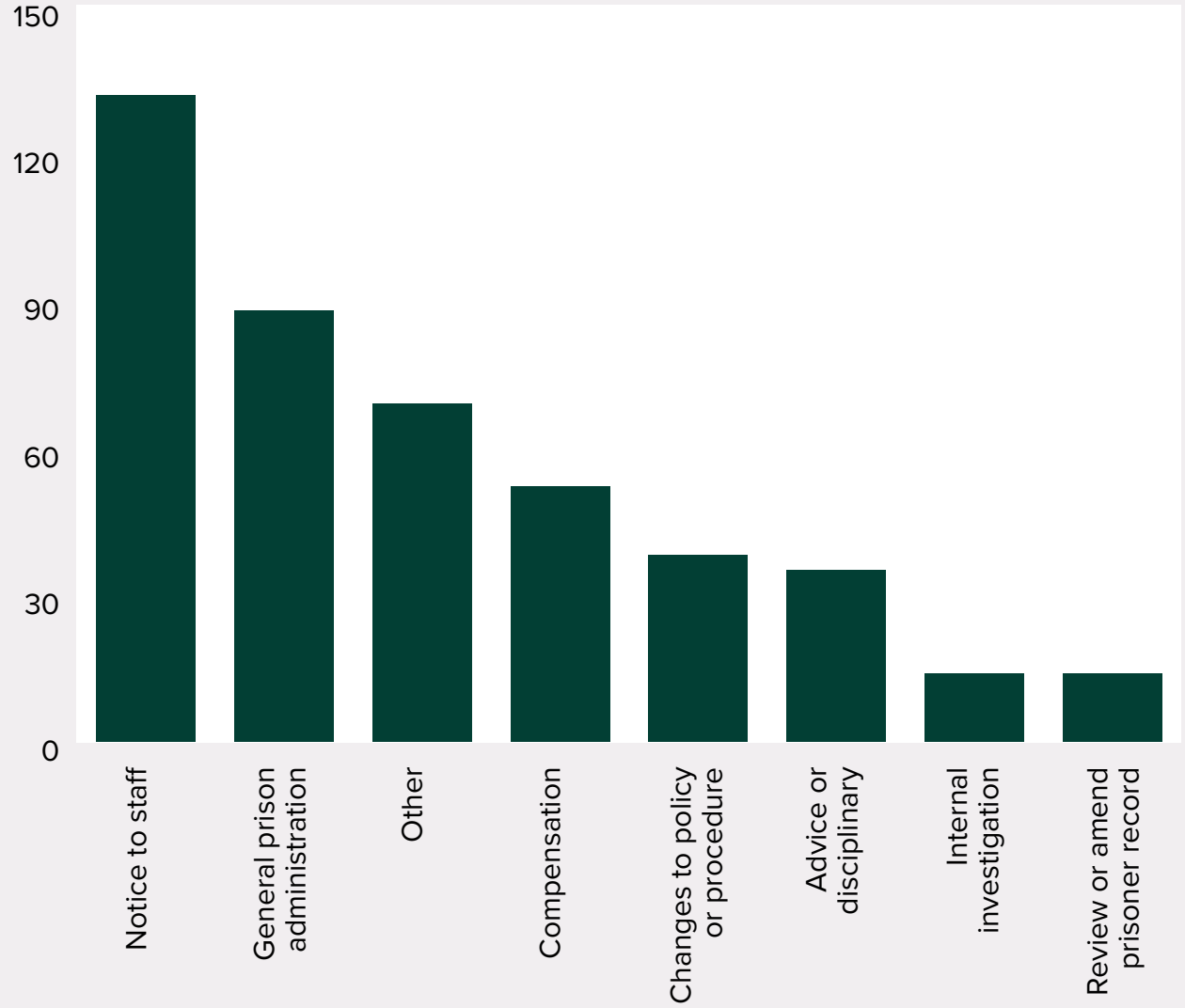
Complaints

We count recommendations about complaints in cases where we have issued the final report within the financial year. Please see the About the data section for more details.

In 2020/21, we made 442 recommendations across 182 cases, with an average of 2 recommendations per case.

We are awaiting a response in a quarter of these recommendations. We have had 2 recommendations rejected. The remaining 329 have been accepted, and we have received evidence of implementation in 76% of these. This is a decrease from 80% in the previous year.

Complaint recommendations, by action (2020/21)



Fatal incidents

We count recommendations about fatal incidents investigations in cases where the final report was issued in the financial year. Please see the About the data section for more details.

In 2020/21, we issued 298 final investigation reports following deaths in custody and made recommendations in 243 of these cases.

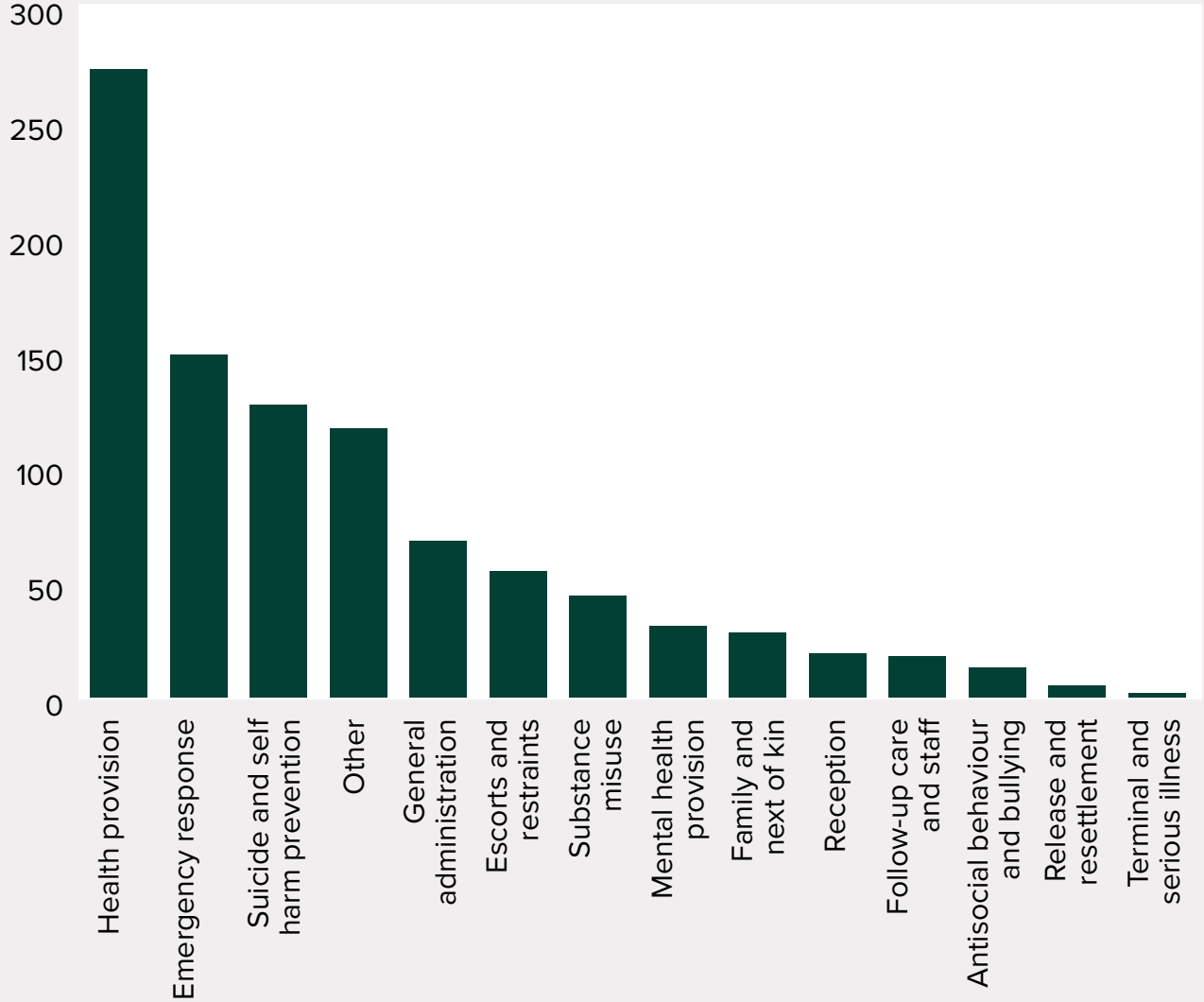
We made 949 recommendations, with an average of 3.9 per case. At the time of writing, most of our recommendations had been accepted (827) and we were awaiting the service response to 121 recommendations. One of our recommendations were rejected by HMPPS.

Health provision recommendations covered a wide range of issues such as the need for robust record-keeping and care plans, following NICE guidance, and prescription medications.

Emergency response recommendations covered staff understanding their responsibilities in emergency incidents including the correct use of the emergency code system, promptly calling ambulances and entering cells without delay.

Our recommendations relating to suicide and self-harm prevention included assessing prisoners based on their risk factors, accurate record keeping and care plans, and following ACCT procedures.

Recommendations following deaths, by category (2020/21)



Stakeholder feedback – emerging findings

We collect feedback from our stakeholders to understand how they engage with our work, their level of satisfaction and to seek suggestions on how we can improve. To that end, the PPO runs four rolling stakeholder surveys to obtain feedback from:

- those with whom we engage (by way of our general stakeholder survey)
- those involved in deaths in custody investigations (by way of our fatal incidents post-investigation survey)
- the next of kin of deceased prisoners (by way of our bereaved families' survey)
- those who complain to us (by way of our complainants' survey)

General stakeholder survey

We ask a broad range of stakeholders for feedback on our performance over the previous year. This includes feedback on our investigations into fatal incidents and complaints.

We received 490 responses in 2020/21, compared to 82 responses in 2019/20. However, this year we have included partial survey responses. (Please see the About the data section for more detail.) The survey ran throughout March 2021 and responses came from prisons (including operational staff, non-operational staff, business staff and other services such as chaplaincy) probation, healthcare services, MoJ, HMPPS and others.

Overall satisfaction

- 90% of the 263 respondents who had some experience of the PPO in the past year rated the overall quality of their experience as satisfactory or better.

Reports

- 42% out of the 266 respondents who answered the question found anonymised fatal incident reports very useful or quite useful.

Our website

- 47% of the 248 respondents who answered the question said they had visited the PPO website in the last 12 months.

Impressions of the PPO

- Of the 244 respondents who answered the question, 73% agreed we were impartial, 79% agreed we were respectful, 69% agreed we were inclusive, 72% agreed we were dedicated and 75% agreed we were fair.[34]

34 Includes those who agreed and strongly agreed.

Post-investigation survey

Following each fatal incident investigation, we send our post-investigation survey to prison liaison officers, establishment heads and healthcare leads within the establishment. We ask that these stakeholders respond to the survey about specific investigations. We also survey coroners at the end of the year about their overall experiences with fatal incident investigations.

We received 208 responses in 2020/21. This is a 28% increase from last year, when we received 163 responses. However, this year we have included partial survey responses. (Please see the About the data section for more detail.) We received responses from liaison officers, establishment heads, healthcare leads and coroners.

Overall satisfaction

- 44 respondents (of the 62 that answered the question) rated the quality of the investigation as good or very good.

Reports and recommendations

- 42 respondents (of the 45 that answered the question) stated the report we issued met their expectations.
- 49 (of the 53 that answered the question) stated that the PPO reports contained about the right amount of detail.
- 47 (of the 54 that answered the question) said they found the recommendations quite useful or very useful.

Impressions of the PPO

- Of the 158 respondents who answered the question, 85% agreed we were impartial, 94% agreed we were respectful, 84% agreed we were inclusive, 91% agreed we were dedicated and 92% agreed we were fair.[35]

Bereaved families' survey

We also send surveys to families or the next of kin of the deceased following our investigations of deaths in custody. A questionnaire is usually sent to bereaved families three months after the final investigation report was issued. Due to COVID-19 restrictions, the surveys were sent out later than that in some cases. (Please see the About the data section for further details.)

We have received 11 responses during this data collection period, compared with 23 responses in 2019/20.

Overall satisfaction

- 6 out of 10 respondents who answered the question felt that the overall quality of the PPO's investigations was very good or good, with a further 3 deeming them satisfactory, and 1 as poor.

Reports

- 5 out of 10 respondents who answered the question felt the initial (draft) report met their expectations.
- Of the 10 respondents who answered the question, 6 thought there was the right amount of detail, with 4 respondents thinking there was not enough.

35 Includes those who agreed and strongly agreed.

Impressions of the PPO

- Of the 11 respondents who answered the question, 6 agreed we were impartial, 8 agreed we were respectful, 5 agreed we were inclusive, 6 agreed we were dedicated and 7 agreed we were fair.[36]

Complainants' survey

We send surveys to a sample of those whose complaints we have investigated in the past year – both to those whose complaints were upheld, and those we did not uphold. We also sample those who have contacted us, but whose complaints were ineligible. A questionnaire is usually sent to complainants two months after the case has been closed, to allow for a rest period where any potential final changes may be made. Due to COVID-19 restrictions, the surveys were sent out later than that in some cases. (Please see the About the data section for further details.)

We received 169 responses in 2020/21, in comparison with 299 in 2019/20:

- 68 responses came from those whose complaints were ineligible. These complaints were not investigated, and the complainants received letters explaining why.
- 101 respondents had eligible complaints. 51 had their complaints upheld or partially upheld and 50 had their complaints not upheld.[37]

Quality of investigation and service

- 35 respondents (of the 50 who answered the question) whose complaints were upheld rated the quality of investigation as either good or very good.
- Of those whose complaints were not upheld, 7 respondents (of the 49 who answered the question) rated the quality of investigation as either good or very good.
- For those whose complaints were ineligible, we asked their opinion about the overall quality of the service they received. Of the 58 who answered the question, 10 respondents rated the service they received as either good or very good.

Reports and letters

- 45 respondents whose complaints were upheld (of the 50 who answered the question) said the report or letter they received was either quite clear or very clear.
- 32 respondents whose complaints we did not uphold (of the 45 who answered the question) said the report or letter they received was either quite clear or very clear.
- 30 respondents whose complaints were ineligible (of the 64 who answered the question) said that our letter explaining why their complaint wasn't eligible was quite clear or very clear. 8 respondents stated they had not received this letter.

36 Includes those who agreed and strongly agreed.

37 Please see the About the data section for what is an eligible, upheld and not upheld case.

Outcome

- 31 respondents whose complaints were upheld (of the 50 that answered the question) agreed or strongly agreed that the PPO helped 'set things right' with their complaint.
- In contrast, only 3 respondents whose complaints we did not uphold (of the 46 that answered the question) agreed or strongly agreed that we helped 'set things right'.
- 11 respondents whose complaints were ineligible agreed or strongly agreed the PPO helped them 'set things right' (of the 62 that answered the question).

Impressions of the PPO

- Of the respondents who answered the question, 36% agreed we were impartial, 65% agreed we were respectful, 52% agreed we were inclusive, 40% agreed we were dedicated and 40% agreed we were fair.[38]

38 Includes those who agreed and strongly agreed. There were different numbers of respondents that answered each question: 151 for impartial, 153 for respectful, 149 for inclusive, 155 for dedicated and 151 for fair.

About the data

Statistical data tables can be found on our website: **https://www.ppo.gov.uk/about/latest-statistics/**. These tables are available for those without internet access by request.

Some totals may not add up to 100% due to rounding.

Some figures have been updated and corrected, and therefore do not match what was published in the previous annual report.

Complaints

Complaint categorisation is based on the substantive element of the complaint. Categorisation is carried out by the assessment team and may be edited by the investigator through the course of the investigation. This can lead to similar complaints being categorised differently.

In May 2020, the PPO added a tick box to the case management system we use, so we could highlight COVID-19 related cases. The following guidance is used to help guide what should be classified as a COVID-19 complaint:

- The COVID-19 category is applied as soon as a COVID-19 related element becomes apparent, from the initial assessment stage to the finalisation of the case. The COVID-19 element is removed if it subsequently becomes apparent that the complaint is not COVID-19 related.
- The COVID-19 category is applied, if relevant, to all complaints, even if the complaint isn't eligible or is subsequently dealt with in line with Paragraph 22, set out in our Terms of Reference.[39]

The COVID-19 flag is added to cases where the complaint:

- mentions COVID, COVID-19, coronavirus, pandemic and/or epidemic in the complaint forms
- relates to any temporary measure or policy put in place by the prison because of the pandemic – for example social distancing, self-isolation, restricted prison visits, education, reverse cohorting units, protective isolation units, shielding units
- relates to access to cleaning products, PPE or access to laundry facilities because of the complainant's concerns about COVID-19
- relates to a lack of staff (includes operational, non-operational staff) where COVID-19 is the cause of the staffing shortage including healthcare, religious ministers, meetings or education provision

In September 2020, we introduced an extra complaint category: video calls. This was created as prisons have started to introduce the ability for prisoners to have video calls with family and/or friends.

A complaint is eligible if it is from a person who has been through the relevant internal complaints process (the two-stage prison process, or the immigration or probation process) and the complainant brings it to us within three months of receiving the final stage reply from the service in remit. The complaint also has to be about something which is within our remit.

39 **https://www.ppo.gov.uk/about/vision-and-values/terms-of-reference/**

A complaint is upheld if, after investigation, we find in favour of the complainant – i.e. we find the service in remit has acted contrary to their local and/or national policy, or otherwise inappropriately or unreasonably. Upheld cases comprise of cases which are upheld and partially upheld.

A complaint is not upheld if we find that the service in remit has acted in keeping with policy, if there is no specific relevant policy, or if they have not acted unreasonably or inappropriately.

Complaints data contained in this report is frozen. Data for 2019/20 was frozen in May and June 2020. Data for 2020/21 was frozen in April 2021. Data for each section was frozen on different days, so represents different cohorts of cases.

A small number of cases received and completed will be counted in multiple years. This only happens when a previously closed case is subsequently reopened after we have received new information over different financial years.

Each case that is ineligible for investigation will be categorised with a reason for its ineligibility. This can happen several times if the complainant continues to send correspondence that would still render their case ineligible, but the reasoning for the ineligibility can update and change.

The number of eligibility letters sent in 2019/20 and 2020/21 refers to letters of eligibility that the PPO sent to complainants in both eligible and ineligible cases. In some cases, the PPO sent multiple eligibility letters about the same case. This happens when a case does not initially meet the eligibility criteria but is later deemed to be eligible when we receive further information. This includes the number of eligibility letters prepared and not sent. This only happens in a small number of cases when we receive a complaint and we are unable to send the eligibility letter – for example if we don't have access to the complainant's release address.

A completed case in 2019/20 and 2020/21 is defined as one where the draft outcome has been approved. This excludes withdrawn and Paragraph 22 cases. We have not been able to calculate how many cases were completed on time as our move to a new case management system resulted in a change in definition. We are continuing to explore ways to collect this data in the future.

Prison population data is taken from the March 2021 population bulletin published on GOV.UK: **https://www.gov.uk/government/statistics/prison-population-figures-2021**

HMPPS complaints data

The HMPPS data used does not represent national statistics, as it comes from an information management tool. The data is 'live' and remains subject to change.

It may not tally with other official statistics and is not 100% accurate as it is not always subject to full checks. We gained prior approval for use and publication of this data.

The HMPPS data reflects the number of prisoner complaints, and those at Morton Hall IRC. The data reflects the number of prisoner complaints raised at the establishment in the period. Complaints where the individual is residing in a different establishment to the establishment they are complaining about are counted in the establishment for which the complaint is about.

The following categories of complaints are included within this data:

- Stage 1/COMP1 forms – where these are to be answered by the establishment the complainant resides in
- Stage 2/COMP1a forms – where these are to be answered by the establishment the complainant resides in
- Confidential Access complaints/COMP2 forms – where these are to be answered by the establishment the complainant resides in or where they are being passed to the IMB or Prison Group Director
- Discrimination Incident Reporting Forms (DIRFs) – where these have been submitted by a prisoner to be answered by the establishment the complainant resides in
- Reserved subject complaints – for example, where an allegation is made against the governor

Recommendations

Complaints' recommendations

Recommendations about complaints are those where we have issued the final report within the financial year.

Recommendations can be amended or removed at any point until the case is closed. This means that, until the case is closed, the data is changeable. The data provided was frozen in May 2021.

Recommendations are categorised by investigators which can lead to similar recommendations being categorised differently.

Accepted recommendations include partially accepted recommendations.

Fatal incidents recommendations

Recommendation data provided covers recommendations which were made in cases where the final report was issued in the financial year.

The data provided was frozen in April 2021.

Recommendations are categorised by investigators which can lead to similar recommendations being categorised differently.

Fatal incident investigations

Data is based on when the PPO were notified of the death.

The PPO does not determine the cause of death. This is determined by a coroner following an inquest. Cases are separated into administrative categories, but these categories may differ from a coroner's conclusions. Classifications may change during the course of an investigation. However, they are not altered following the conclusion of the inquest. A small number of classifications for previous years have been updated for this publication, so may not match what has previously been published.

Self-inflicted deaths: The death of a person who has apparently taken their own life and the circumstances suggest this was deliberate, irrespective of whether this would meet the legal definition of intent (i.e. suicide).

Homicide: Where one person has killed another, irrespective of their level of intent.

Natural causes: Any death of a person as a result of a naturally occurring disease process that is organic and not triggered by something non-natural.

Other non-natural: These deaths have not happened organically; they are non-natural but cannot be readily classified as self-inflicted or homicide. They include accidents and cases where the post-mortem has not ascertained a cause of death. This category also includes drug-related deaths where there is not enough evidence to classify them as a self-inflicted death.

Awaiting classification: These are deaths where there is currently no indication of the cause of death.

COVID-19 related fatal incident investigation: A death in a person where COVID-19 is mentioned on the death certificate or post-mortem report. Deaths are recorded as COVID-19 from the outset of the investigation if there appears to have a COVID-19 element. If information provided later shows the death does not fit our definition, it will be re-categorised. It is important to note, death certificates are not always consistently filled in.

Fatal incident data was frozen in early May 2021.

The PPO and HMPPS have different defining criteria for classifying cases. For this reason, the totals in each category may differ from what is published by HMPPS.

Initial reports are counted as having been completed 'in time' when the report is issued within 20 weeks of the date of notification for natural cause deaths which were originally classed as natural causes, and 26 weeks for all others (including those that are unclassified at the time of notification). However, we must sometimes suspend our investigations while we wait for key information, such as the cause of death, toxicology tests or a clinical review. Timeliness calculations exclude the times when a case is suspended for reasons that are outside the PPO's control.

Final reports are counted as having been completed 'in time' when the report is issued 12 weeks following the initial report.

Timeliness is calculated based on working days and excludes bank holidays.

Surveys

Throughout the surveys, some respondents did not answer all the questions and, depending on certain question responses, some respondents were not asked all questions. This year we included partial survey responses in the data. In previous years we have excluded partial survey responses.

General stakeholder survey

The general stakeholder survey is an online survey that was promoted on Twitter, our website and sent to those on our stakeholder mailing lists. It was sent out at the beginning of March 2021, with a reminder email being sent two weeks later. The survey was then closed at the end of March 2021.

Bereaved families' survey

The survey is sent monthly to family members and/or next of kin who have been sent a final report three months previously. Due to the COVID-19 restrictions, the survey was paused in March 2020. Surveys which were due to be sent out between March 2020 and August 2020 were sent out in August 2020 when the survey resumed. The survey was paused again in January 2021 due to COVID-19 restrictions. Therefore, survey results presented in this annual report are reflective of cases where a final report was issued in December 2019 to September 2020. Surveys which were due to be sent out between January 2021 and March 2021 were sent out in April 2021, and therefore will be included in our 2021/22 analysis.

Complainants' survey

The survey is sent monthly to a sample of complainants who have had their complaints closed. This includes:

- a sample of eligible cases
- a sample of ineligible cases
- a sample of ineligible probation cases
- all eligible probation cases
- all eligible and ineligible cases from women
- all eligible and ineligible cases from those in immigration removal centres
- all eligible and ineligible cases from those aged 21 and under

We send our surveys two months after the case has been closed, to allow for a period where any potential final changes may be made.

Due to the COVID-19 restrictions, the survey was paused in March 2020. Surveys which were due to be sent out between March 2020 and July 2020 were sent out in August 2020, when the survey resumed. Due to the small number of complaint cases closed in April 2020, May 2020 and June 2020, all individuals which had a case closed in these months received a survey and normal sampling was not carried out. The survey was paused again in January 2021 due to COVID-19 restrictions. Therefore, survey results presented in this annual report are reflective of cases closed between January 2020 and October 2020.

Surveys which were due to be sent out between January 2021 and March 2021 were sent out in April 2021 and will be included in our 2021/22 analysis.

Ineligibility reasons are updated and overwritten every time a new eligibility assessment has been completed when new information is provided. Therefore, the outcome of the cases included in the sample may have changed after sampling.

Post-investigation survey

The post-investigation survey is sent to PPO liaison officers (the prison officer who has been the main point of contact for the PPO investigator) once the draft report has been issued, and to establishment heads and healthcare leads after the final report has been issued. It is sent out at the beginning of each month, for the previous month. Timings of when the survey was sent out were slightly different in 2020/21 due to COVID-19. The results presented include cases which had their reports issued between April 2020 and February 2021. Cases where reports were issued in March 2021 will be included in the 2021/22 survey results. It is also sent to coroners who have been involved in fatal incident investigations that had a fatal incident final report issued in 2020/21, with a two-week allowance for completion. These results are then combined.

Financial data

	2019/20		2020/21		Change 19/20 to 20/21	% change year on year
Budget allocation	£5,507,000		£5,627,000		£120,000	2%

Actuals	2019/20	% of total 19/20	2020/21	% of total 20/21	Change 19/20 to 20/21	% change year on year
Staffing costs	£5,055,492	93%	£5,079,267	94%	£23,775	0%
Non-staff costs	£394,234	7%	£338,224	6%	-£56,010	-1%
Total spend	**£5,449,726**	**100%**	**£5,417,491**	**100%**	**-£32,235**	**-1%**
Underspend	**£57,274**		**£209,509**		**£152,235**	**3%**

Terms of Reference

Please visit our website for our full Terms of Reference:

https://www.ppo.gov.uk/about/vision-and-values/terms-of-reference/

If you do not have access to the internet, please write to us at the following address to request a printed copy:

Prisons and Probation Ombudsman

10 South Colonnade
Canary Wharf
London
E14 4PU

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