Prisons and Probation Ombudsman Stakeholder Survey 2013

Executive summary

- This paper presents the results of the annual PPO stakeholder feedback survey; it outlines results from 2013 and makes comparisons to 2012 feedback.

- In total, 179 responses were received from a range of people who had experience of the PPO during the preceding year. These include frontline staff across prisons and probation, and others such as HM Coroners and Clinical Reviewers.

- Although nearly two thirds of those involved with either complaints or fatal incident investigation felt that investigations had been completed quickly enough or better, timeliness remained a concern for some stakeholders.

- For both complaints and fatal incident investigations, seven in ten respondents felt they were kept informed of progress

- The Annual Report continued to be the most widely read publication by the PPO with over 80% finding it useful.

- The three thematic publications and five learning lessons bulletins were popular. The fatal incident investigation focused *End of Life care* thematic was most widely read by respondents (120 in total) with nearly 90% finding the publication quite or very useful.

- Quality remained high with at least 65% rating the PPO overall as ‘good’ or ‘very good’.

- General impression scores remained high with at least 90% rating PPO as ‘very’ or ‘quite’ influential, independent, professional and accessible. There was also an increase across all the areas for the ‘very’ rating. The ‘professional’ rating remained the highest as in previous years.

- Respondents also indicated areas where the PPO had worked well and where improvements could have been made. The PPO thanks everyone for these comments and will use them to celebrate success and develop services in the future.

1. Introduction

The Prisons and Probation Ombudsman (PPO) routinely collects feedback from a range of stakeholders; these include prisoners, people on probation supervision, immigration detainees, bereaved families and organisational stakeholders.

This report focuses on the feedback from organisational stakeholders through the annual PPO stakeholder survey.

The survey is designed to identify stakeholders' perceptions of the PPO and find out what they think of PPO investigations, reports and work in general. It is also designed to assess the external profile of the PPO and what improvements could be made.

The information gathered can subsequently be used by the PPO as a management tool to improve services where appropriate. The report does not attempt to highlight areas where perception differs from reality, explain where changes have already been put into place or defend any criticisms.

2. Methodology

The survey was sent electronically to stakeholders in November 2013. The same stakeholder groups were targeted as in previous years.

Targeted emails were sent to three groups (Governors and Directors/Controllers, Heads of Healthcare and HM Coroners) to encourage their participation and to provide an overview of future stakeholder feedback exercises that the PPO will conduct. All other stakeholders received the general stakeholder invitation.

When distributed to establishments and other organisations an instruction was included for it to be passed on to anyone who may have had contact with the PPO. This method aims to access as many stakeholders as possible but means we were not able to quantify how many potential respondents there were or calculate a response rate.

3. Responses

The survey was completed by 179 people (Figure 3.1) who indicated that they had had contact with the PPO during the previous 12 months. This was lower than the 219 responses received in 2012.

Figure 3.1: breakdown of responses by role and organisation

	Total responses		Total	Involved with complaints investigations	Involved with fatal incidents investigations
Prison	99	Director/Controller	1	1	1
		Governing governor	16	12	12
		Head of Healthcare	26	8	19
		Prison Healthcare other	1		1
		Other governor	38	21	27
		Other role	17	6	7
Probation	10	Approved premises manager	3		
		Chief Officer	3	2	1
		Secretary to the Board	1	1	
		Other role	3	1	
Healthcare / NHS England	15	Clinical reviewer	9		9
		Healthcare commissioner	4		3
		Other role	2		1
Home Office Immigration Enforcement	5	Custody manager	1		
		Head of Healthcare	1		
		Other role	3	1	1
HM Coroner	11	HM Coroner	11		10
IMB	17	IMB	17	1	9
Other	22	Central Government (inc MOJ and NOMS)	10	6	6
		HM Inspectorate	4		
		Legal services	1		
		Prisoner escort and custody services	2		1
		Third Sector	4	1	1
		Other	1		
TOTAL	179		179	61	109

Nearly three-quarters (129) of respondents had been directly involved with investigations during the year. Of these, 61 had experienced complaints investigations and 109 had been involved with fatal incident investigations – these figures included 41 people who were involved with both types during the previous year.

4. Findings

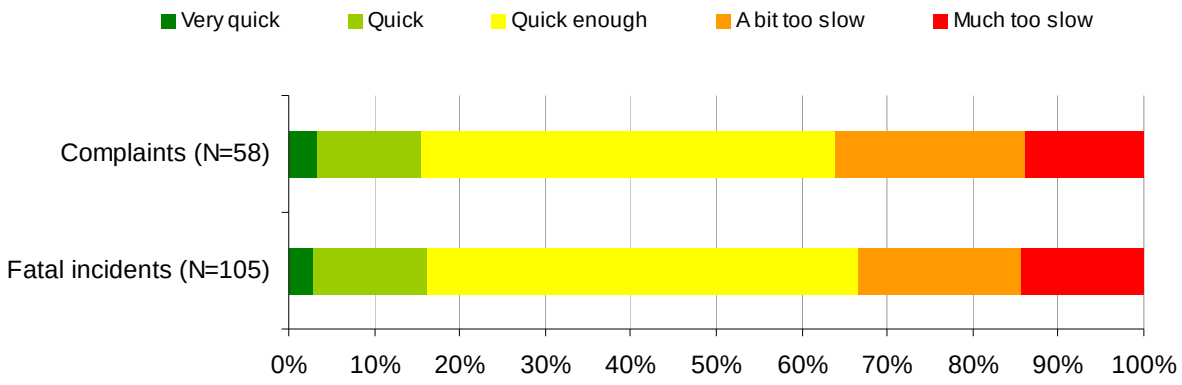
4.1. Timeliness

Respondents who had been involved with complaints and/or fatal incident investigations in the last twelve months were asked to assess how long they took to complete. Where respondents had experience the year before, they were asked if they had noticed any change.

4.1.1. Timeliness in 2013

Nearly two thirds (37) of respondents felt that complaints investigations this year had been completed quickly enough or better (Figure 4.1). Just over a fifth (13) felt they were completed a bit too slowly and eight respondents felt investigations were much too slow.

Figure 4.1: Timeliness of investigations



Prison staff were most commonly involved with complaints investigations (46). As with the overall data, nearly two thirds felt that complaints investigations were completed quickly enough or better.

Two thirds (70) of respondents involved in fatal incident investigations felt the investigation was quick enough or better. Nearly a fifth (20) felt the investigations were a bit too slow and a slightly smaller proportion (15 respondents) felt they were much too slow.

Again, prison staff were the most commonly involved (65 respondents) with the investigations and felt they were completed quickly enough or better, in line with the overall results.

> *"I think this is dependant on the Investigator. My recent involvement with one of your team has been very positive. We have been able to work through and overcome hurdles positively because of a good working relationship respectful of each others commitments." (Prison – Other governor)*

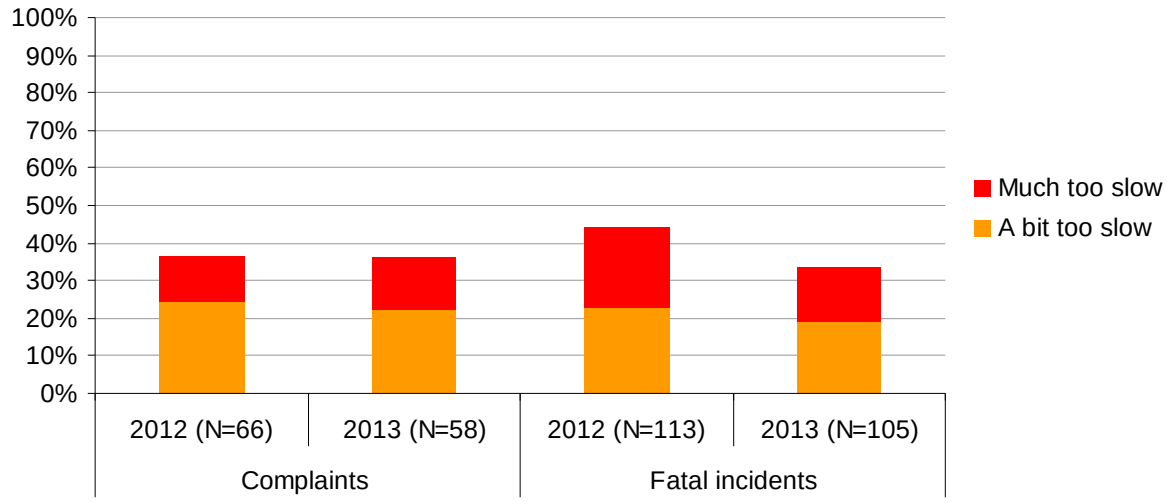
However, coroners (10 respondents) were more negative with eight stating that investigations were too slow.

> *"Must produce reports faster & with more attention to the broader picture. Delay in the production of the report has a serious knock on effect in the inquest process" (HM Coroner)*

4.1.2. Timeliness comparison to 2012

The proportion of respondents who felt that complaints investigations were too slow in 2013 (36%) is broadly the same as 2012 (Figure 4.2).

Figure 4.2: Timeliness of investigations comparison 2012-2013



Of the 40 respondents who had experience of complaints investigations in both years most of these (23) felt there was no change, 10 respondents (25%) felt this was quicker and 7 (18%) felt that it was slower than in 2012.

The proportion of respondents who felt fatal incident investigations were too slow fell from 44% to 33% between 2012 and 2013.

This improvement is also reflected in the responses from those who had experience with investigations in both years (80): 31 (39%) felt that investigations were quicker than in 2012. Six people felt that investigation times were slower than the year before.

> *"I have had to tick the 'much too slow' box due to the huge delays with publication of the report from a DIC [death in custody] from 2011. However, sadly, my prison experienced two further DIC's within the past 12 months and the PPO investigations have been far more timely." (Prison – Governing Governor)*

Although improvement was noted by respondents, timeliness of investigations remains an area of concern for respondents. This will be explored later in section 6.

> *"We had one completed very quickly however others have taken much longer." (Prison – Other Governor)*

4.2. Being kept informed

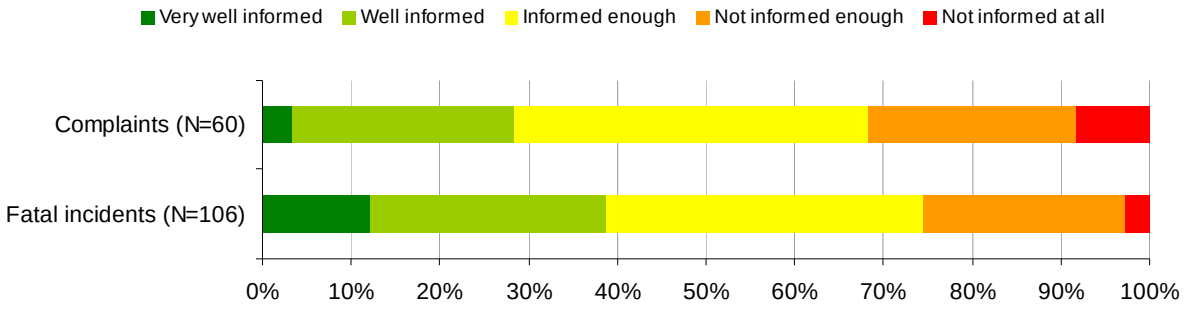
Respondents were asked how well they felt they had been kept up to date with the progress of investigations. Where respondents had experience in the year before, they were asked if they had noticed any change.

For a general survey like this, it is not possible to separate those who should be kept informed from those who do not have a close involvement with the case. For instance, governors would be involved in some but not all complaints. It is hoped that this would be taken into consideration by respondents when completing this question and those who would

not expect to be kept informed would answer with 'informed enough'. However, as this is not in the wording of the question, the response may be misleading.

4.2.1. Being kept informed in 2013

Figure 4.3: Progress of investigations



Nearly seven in ten (41) respondents who had experience of complaints investigations felt that they had been informed enough or better.

> *"the initial investigation, feedback and general engagement locally was extremely prompt and helpful. This schedule ensured staff could contribute whilst the tragic events were still fresh in their memory and the prison could make swift adjustments to the areas risk identified by the PPO review." (Prison – Governing Governor)*

Nearly a quarter (14) felt they had not been informed enough and five felt they had not been informed at all.

> *"Single point of contact has been with a prison governor with no direct contact with the health care department, as a result communication has on occasions been confused and sporadic" (Prison – Head of Healthcare)*

Responses for complaints investigations were broadly similar across role types although four of the eight prison-based Heads of Healthcare stated that they were not sufficiently informed.

> *"The PPO needs to liaise more with healthcare directly and not go through the prison all the time as often messages are not received or delayed." (Prison – Head of Healthcare)*

Three quarters (79) of respondents felt they were kept informed during fatal incident investigations. About one in five (24) felt they were not informed enough and a further three respondents felt they were not informed at all.

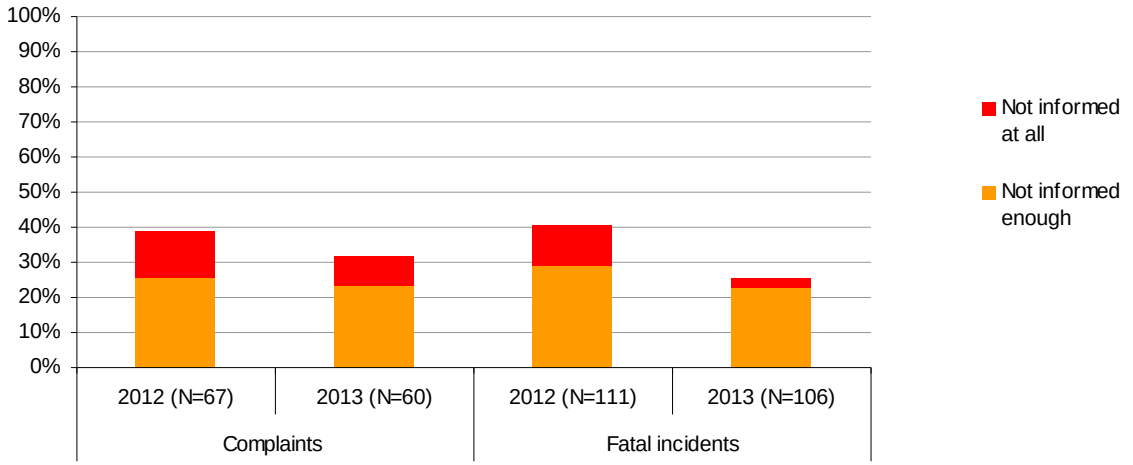
Again, prison-based Heads of Healthcare felt they were not informed enough (seven out of 18 respondents). As in previous years, coroners were also more negative than the rest about

fatal incident investigations with four (out of ten) feeling that they were not sufficiently informed.

4.2.2. Being kept informed of progress comparison to 2012

Nearly a third of respondents who had been involved with complaints investigations in 2013 felt that they were not sufficiently informed (Figure 4.4). This is slightly lower than in 2012 (39%).

Figure 4.4: Being kept informed during investigations comparison 2012-2013



Of the 42 respondents who had experience of complaints investigations in both years; most of these (32) felt there was no change. Eight respondents (19%) felt this was quicker and two (5%) felt that it was slower than in 2012.

The proportion of respondents who felt they had not been kept sufficiently informed during fatal incident investigations fell from 41% to 25%.

Similarly, 23 respondents (31%) who had experience of fatal incident investigations over both years said they were better informed in 2013, 44 respondents felt there was no change and eight said they felt less informed than 2012.

4.3. Reports

Respondents were asked whether they had read either complaints or fatal incident reports during the last twelve months and those who had were invited to comment.

4.3.1. Complaints investigations reports

Sixty-six respondents had read complaints investigations report with 18 people providing comments.

As in 2012, positive comments were focused on two key areas; content of the report and clarity of writing:

"Exception reporting style and factual clarity of the reports are positive." (Prison – Governing Governor)

"I have found the report to cover all aspects of the investigation into the complaint and was very clear in its presentation." (Prison – Governing Governor)

"Useful, clear and easy" (Prison – Governing Governor)

However, five respondents said that they felt complaints investigations focused more on the views of prisoners than prison staff resulting in unbalanced findings:

"Very thorough in terms of content although sometimes I feel investigators stress and/or highlight the negatives of prison staff instead of providing a balanced view of an individuals performance. For example; you may have an Officer with an unblemished record and a really positive conduct report be involved in a decision or incident which is completely out of character. I feel the investigators are extremely quick to point out 'what went wrong' or 'what was done wrong' instead of balancing it against what mitigating circumstances they may be. I certainly do not condone irresponsible or wrong behaviour amongst staff but I do believe that we all at some point can be subjected to making a mistake. The reports sometimes read that the investigator believes and/or takes side with a prisoner's complaint without taking into consideration the above factors." (Prison – Other Governor)

"Sometimes it appears not to have fully explored the prison aspect of complaints and only taken the first contacted person's response - but that is more about the staff not fully appreciating PPO role and how their comments can impact on PPO report and findings" (Prison – Other Governor)

"The report and investigation I was involved in did not seem to adequately reflect the views of the prison and took the prisoner's word on face value. There were elements of poor record keeping on the prison's part but this should not amount to our views not being reflected" (Prison – Other Governor)

4.3.2. Fatal incidents investigations reports

One hundred and twenty-seven respondents had read complaints investigations reports with 52 people providing comments:

"I think the format was easy to follow and the content was appropriate to the PPO report" (Prison – Head of Healthcare)

"Very thorough and accessible to people not necessarily directly involved." (IMB)

"Clearer guidance regarding clinical review format has helped clarity" (Clinical reviewer)

As with previous questions, responses also noted improvements in fatal incident investigation reports:

"The format and standard of the FII reports have improved over the past 12 months." (Central Government including MOJ and NOMS)

"These are vastly improved. They are clear to read make realistic recommendations but perhaps what has been more evident in the reports has been a move towards greater independence and transparency." (HM Inspectorate)

Negative comments were related to report consistency and expectations of prison staff:

"The PPO reports tend to be accurate however we feel there could be more consistency in the investigative approach, for example, some investigators have higher expectations of the safer custody dept which can be unrealistic. There have been some instances where an investigator could access the necessary information themselves but has requested a prison member of staff do this on their behalf". (Prison – Other Governor)

"I think that the PPO could be more positive when staff have gone 'over and above' in their duty of care. I have managed a number of deaths in custody that have arisen from prisoners being terminally ill and thus protracted events. I don't feel that the PPO has always adequately acknowledged the work, skills and commitment required to enable prisoners to die with dignity." (Prison – Other Governor)

Coroners also raised points and provided suggestions to improve PPO reports (see section 6).

"Content is generally adequate. However I have noticed a tendency this year for slightly less full detail and references to 'a nurse', 'a doctor' rather than identifying the individual by name. In addition there seems to be fewer interviews of relevant staff." (HM Coroner)

"They are usually good for producing a chronology but are often lacking in what I want from them, but that may well be as a result of our different roles" (HM Coroner)

"The medical reports are still not always helpful. Firstly, having a medical report written by a trust manager is largely irrelevant as what one needs to know is was the treatment within the scope of a GP/nurse/healthcare worker acting reasonably and for that you need someone in the relevant speciality. Furthermore, when a patient gets lost to NHS follow up you usually focus on the NHS mistake not on why the prison did not chase the appointment up and correct the mistake. Also in these cases you make no investigation of the hospital and do not notify the Coroner of this outstanding piece of evidence which means when the report arrives I have to then start on this aspect flat footed six months late." (HM Coroner)

4.4. Publications

Stakeholders were asked whether they had seen the various PPO publications in the last twelve months and to rate how useful they found them. This is sub divided into general publications and communications that are completed on a regular basis, stakeholders' feedback publications, and 'Learning Lessons' publications based on wider learning from PPO investigations. Thirteen respondents (7%) had not seen any of the publications in 2013, similar to the 6% in 2012.

4.4.1. General publications

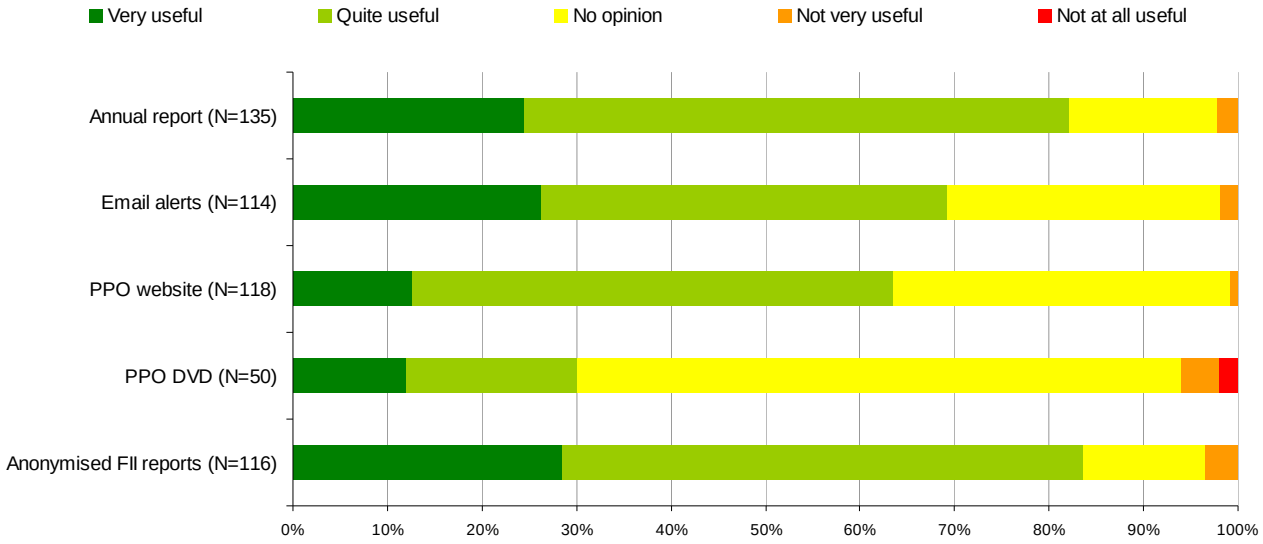
The annual report remains the most widely seen general publication by the PPO with three quarters (135) of the stakeholders viewing it in 2013 (Figure 4.4). This is similar to that of 2012.

Similarly, the proportion of respondents viewing other general publications has remained broadly similar to 2012 with the DVD remaining as the least seen, by nearly three in ten respondents.

The anonymised fatal incident investigation reports were found to be the most useful publications (Figure 4.5) with more than eight in ten who had seen the reports finding them 'quite' or 'very' useful. Only four respondents (2%) stated that they were not very useful.

Similarly, 97 out of the 116 respondents (82%) who had seen the Annual report found it useful.

Figure 4.5: Usefulness ratings of PPO general publications



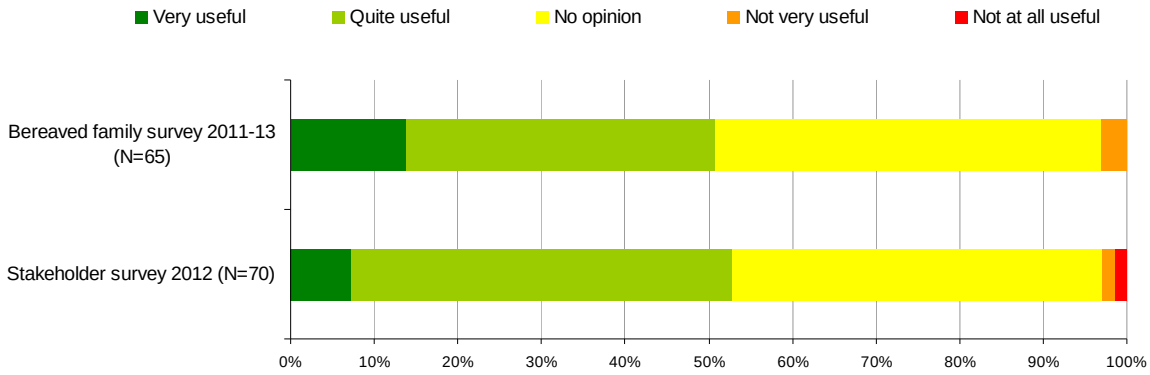
As in 2012, the PPO DVD was found to be least useful for the stakeholders, 64% had no opinion with a further 6% stating that it was not very or not at all useful.

4.4.2. Stakeholder feedback

As part of the stakeholder engagement strategy, the PPO conducts an ongoing survey of bereaved families and the annual survey for stakeholders outlined in this report.

Just over one in three respondents had read the survey publications and just over half felt that the publications were useful or very useful. One respondent felt that the stakeholder feedback publication was not at all useful.

Figure 4.6: Usefulness ratings of PPO stakeholder feedback publications



4.4.3. Learning lessons publications

Since November 2012, eight publications aimed at learning lessons from investigations have been produced by the Ombudsman. These are split into issues-based publications containing in-depth statistical and themed analysis, and shorter case study-based bulletins.

Overall, the thematic publications were found to be useful to respondents (Figure 4.7). The fatal incident investigation focused *End of Life care* thematic was most widely read by respondents (120 in total) with nearly 90% finding the publication quite or very useful.

The bulletins were found to be slightly less useful than the thematic publications (Figure 4.8). The *Learning from the use of restraints* was most widely read (82 respondents) with nearly three quarters finding it useful.

Figure 4.7: Usefulness ratings of PPO thematic publications

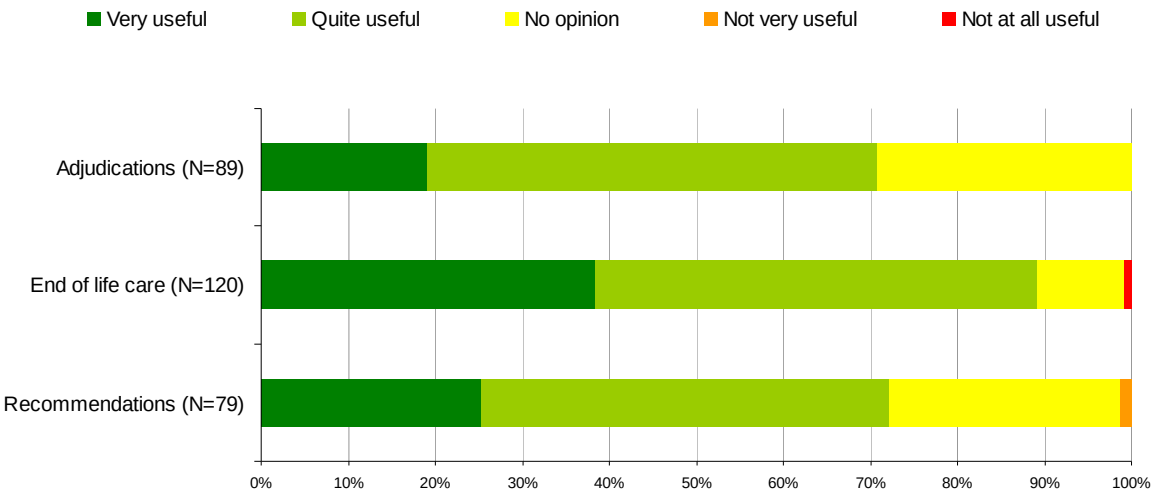
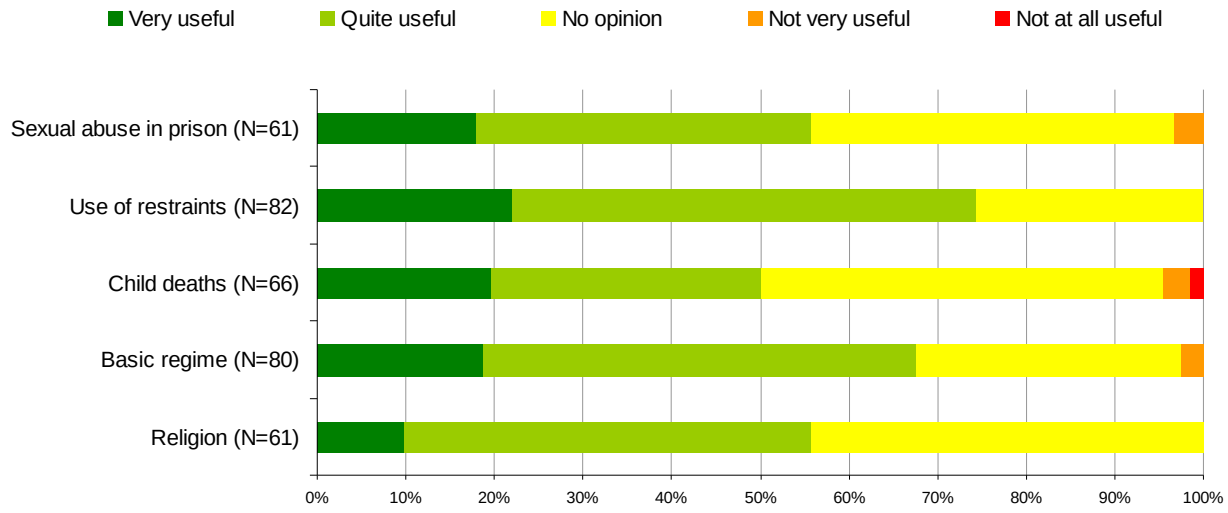


Figure 4.8: Usefulness ratings of PPO learning lessons bulletins



4.4.4. Comments about publications

Positive comments included where prisons had taken action as a result:

> *"Prompted us to look at our own practices." (Prison – Other Governor)*

> *"The learning the lessons reports were very good" (HM Inspectorate)*

Comments were also made that dissemination was not wide enough and suggestions were provided to improve accessibility:

> *"I would be interested in several of the above bulletins. Not sure how they are promoted. To be honest I don't use the website, but if these reports were promoted more, they might get more readership." (Prison – Governing Governor)*

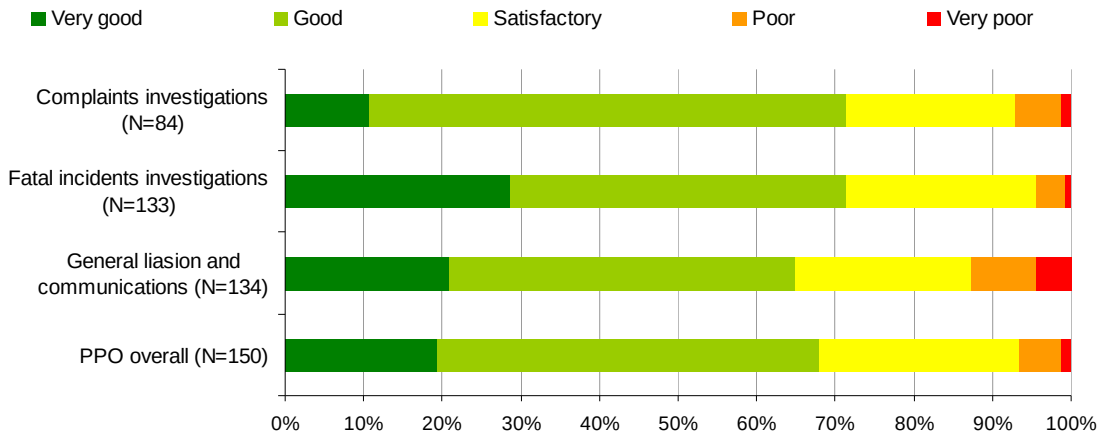
> *"Website/reports on website need to be legible on tablets/smart phones." (HM Inspectorate)*

4.5. Quality

Respondents were asked to rate the quality of service across the three areas of PPO work (complaints investigations, fatal incident investigations and general liaison and communication) and for the PPO overall.

4.5.1. Quality ratings in 2013

Figure 4.9: Quality ratings of PPO work



The majority of respondents who had experienced PPO investigations in the past twelve months rated them as 'good' or 'very good' (71% for both complaints and FII investigations). As in 2012, general liaison and communications was slightly lower at 65%. For the PPO overall, nearly seven in ten felt that quality was 'good' or 'very good' (Figure 4.9). Positive comments relating to quality included:

> *"The fact that we have had a number of deaths in custody has allowed us to develop relationships and understand how the PPO operates. It has been evident that there is now a differential approach to deaths caused through terminal illness and this has been a positive step forwards." (Prison – Other Governor)*

> *"The communication and support my team and the escort contractor investigator's have received has been excellent. The PPO team have been extremely supportive." (Other - Prisoner Escort and Custody Services)*

4.5.2. Quality ratings comparison to 2012

Across all of the areas, less than 13% of respondents rated the quality of PPO work as 'poor' or 'very poor'. This was broadly the same as 2012 feedback.

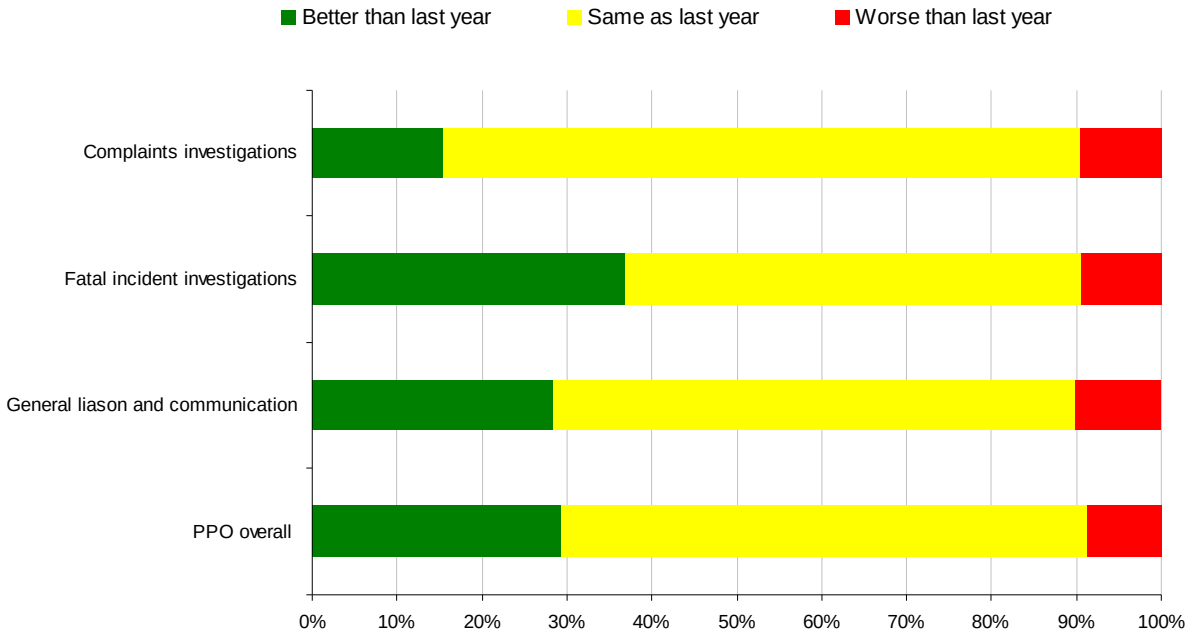
Comments related to instances of perceived poor quality included:

> *"Some of the requests made are vague and upon seeking clarity, this has proven to be challenging. Deadlines issued in some cases have been unrealistic." (Prison – Other role)*

> *"The reports are useful, however in terms the process, the reports are issued in draft form to the families before the providers like healthcare get an opportunity to comment or potentially dispute, this could lead to potentially incorrect information being given to families that will be challenged at a later date." (Prison – Head of Healthcare)*

Of those who could compare quality for both years, the majority thought there was no change (Figure 4.10). More than a third (37%) noticed improvements in fatal incident investigations. Just under one in three also noticed improvements in general liaison and communications and the PPO overall. Improvements in quality were also observed by eight respondents (15%) who had experienced complaints investigations. However, across all the areas about one in ten respondents thought that services had got worse.

Figure 4.10: Change in quality of PPO work



4.6. General impressions ratings (Professional/Independent/Accessible/Influential)

The general impression ratings are four key characteristics that the PPO works to within all activities. The PPO strives to ensure that all people rate the office as 'very' for each characteristic.

The four characteristics are:

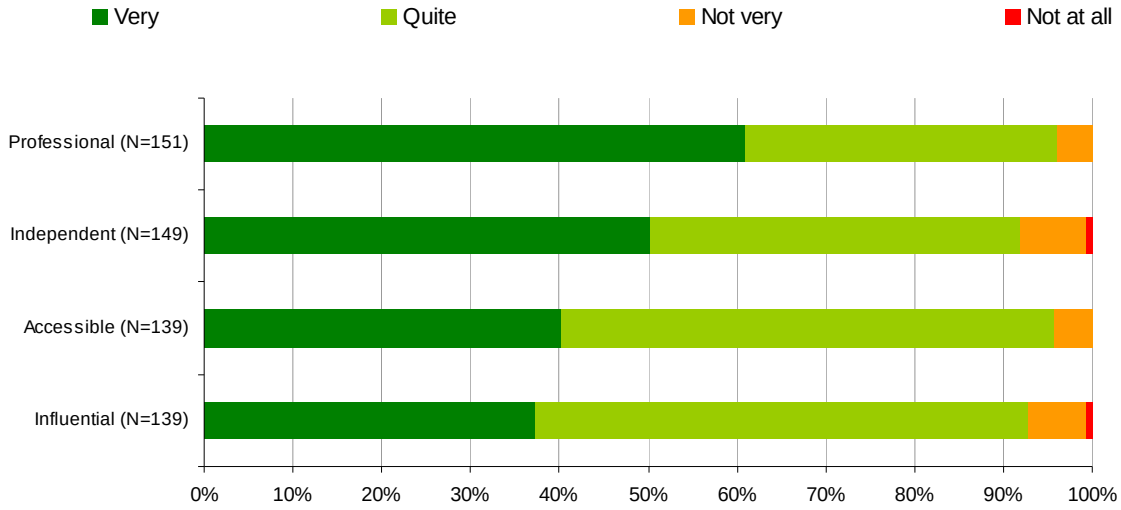
- Professional (operates in a professional manner)
- Independent (unbiased, fair and impartial)
- Accessible (easy to get in touch with when necessary)
- Influential (able to make a difference)

Over 92% rated the PPO as 'very' or 'quite' on each of these characteristic. As with previous years, the professional scale rated the highest with 145 (96%) responses at this level (Figures 4.11 and 4.12).

Figure 4.11: General impression ratings responses

	Professional (N=151)		Independent (N=149)		Accessible (N=139)		Influential (N=139)	
Very	92	61%	75	50%	56	40%	52	37%
Quite	53	35%	62	42%	77	55%	77	55%
Not very	6	4%	11	7%	6	4%	9	6%
Not at all	0	0%	1	1%	0	0%	1	1%
	151		149		139		139	

Figure 4.12: General impressions ratings responses



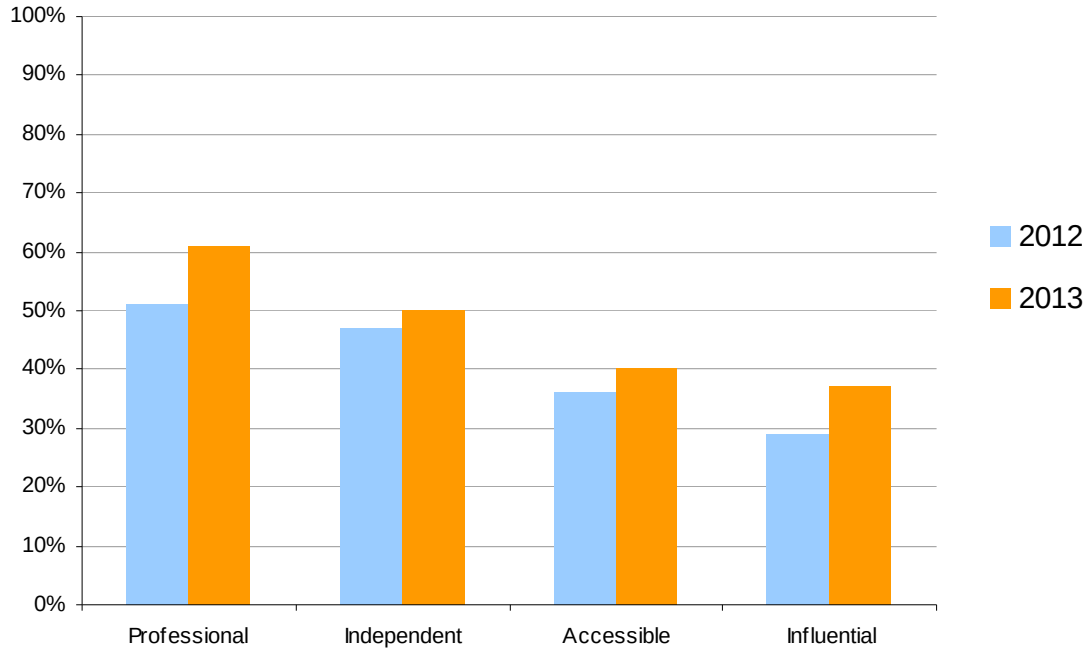
Positive comments related to ratings included the following:

> *"In my dealings with PPO I have always found it to be a good experience with very clear communications and a level of patience when waiting for information to be provided, which is very refreshing in today's very busy working environment." (Prison – Other Governor*)

> *"Putting forward PPO views via Inside Time was good" (IMB)*

In comparison to 2012, there has been a small increase in the number of 'very' ratings across all the categories (Figure 4.13). The increase varied between three and ten percentage points. As with previous years, the professional category is rated highest and influential has the lowest proportion of 'very' ratings.

Figure 4.13: Changes in proportion rating the PPO as 'Very…'



Negative points were raised by six respondents related to ratings and included the following:

"It has been noticed that some [complaints] reports have included 'assumed' comments and are more the Investigator's personal opinion rather than there being evidence that something has taken place. In order for the PPO to maintain its independence, unless the Investigator has obtained the evidence necessary to support such comments, then these should not appear in the reports. Adjudicators have to be satisfied beyond reasonable doubt and cannot base their findings on assumptions. The PPO's investigations should be the same in order to be fair to both sides of the complaint." (Central Government including MOJ and NOMs)

"Although on one occasion I found the investigator to have very fixed views" (Prison – Head of Healthcare)

5. What the PPO did well

Respondents were asked whether there was anything in particular that the PPO had done well in the previous year. As with 2012, comments focused on supportive communication with staff, professional approach taken, the impact of learning lessons publications and improved timeliness of fatal incident reports. Below is a selection of these comments:

"Sensitive treatment of staff when dealing with DIC investigation. Letter of recognition to governor regarding staff actions - providing re-assurance. Approachable and professional." (Prison – Other Governor)

"The annual reports, fatal incident reports are hugely improved over what they used to be." (Prison – Head of Healthcare)

"One investigation was completed very quickly which meant that staff recollection of events was the best it could be and they were able to move on from the tragic death in a timely way." (Prison – Other Governor)

"I imagine that the work the investigators undertake is a very challenging and difficult one, especial investigations into deaths in custody and I admire their dedication to this and to getting a true and balanced picture of these." (Prison – Other Governor)

"This is a well lead organisation of very caring and competent people who are set up to fail by very poor funding and infrastructure" (HM Coroner)

"Hand holding for a newly appointed coroner" (HM Coroner)

"Visit by Ombudsman and Deputy provided extremely useful feedback, review and engagement opportunity. Thank you." (Prison – Governing Governor)

I deal with the initial investigators and find all to be professional, courteous and grateful for my help. (Prison – Other role)

"Circulating IMB boards with reports on deaths in custody has been a good thing." (IMB)

"Cover attendance at Inquest hearings" (HM Coroner)

"Bulletins are really useful and I send them out on our monthly bulletin so all staff are aware." (Prison – Other Governor)

"The timeliness of the reports have improved" (Prison – Other Governor)

"Speed turning around draft reports has improved" (Healthcare – Clinical Reviewer)

6. What the PPO could do better

Respondents were asked what they felt the PPO could have done better over the 12 months. Below is a selection of the comments received. All comments will be considered by the PPO senior management as part of the continuous review of work processes.

Liaison and communication of information was most commonly suggested as an area for improvement, in particular ensuring that changes in findings were communicated:

> *"Make an establishment fully aware when the direction of a report changes significantly from the original findings/discussions." (Prison – Other governor)*

> *"PPO do not communicate well with third party stakeholders such as healthcare. It is typical of the attitude to healthcare that the TOR and other communications to staff to attend for interviews is often issued ,within two hours of the PPO wanting to interview them. This is unacceptable practice. Healthcare staff are not treated with the same process as officers are." (Prison – Head of Healthcare)*

> *"Whilst I realise that it must be very frustrating trying to organise interviews for staff in one visit at times it is just not possible to do this as staff are not available. This will become harder in the future with the availability of staff effected my new shift patterns and staff reductions. (Prison – Other Governor)*

> *"Letting us know about visits, if only by insisting that the prison officer involved contact the IMB" (IMB)*

> *"My only issue is that when the PPO requests info to answer complaints, to be aware if that prisoner is no longer at that establishment or released it can at times prove difficult to collate some information." (Prison – Other Governor)*

> *"I would like to be made aware of the outcome of investigations (even if its just to say (upheld / rejected) although understand that this is not necessarily possible." (Prison – Other)*

> *"…it would be useful to have a timeline of when investigations are completed for inquests as staff dwell over issues." (Prison – Other Governor)*

Although many respondents acknowledged improved timeliness in report writing, other respondents, particularly coroners, raised timeliness of reports remained a concern:

> *"Must produce reports faster and with more attention to the broader picture. Delay in the production of the report has a serious knock on effect in the inquest process" (HM Coroner)*

> *"Speed up availability of reports" (HM Coroner)*

> *"Speed of pretty much all investigations and quality of many…" (Third Sector)*

Other comments addressed specific PPO strategic approaches:

> *"It can be helpful to discuss issues that are going to appear in the report before it is circulated as a draft. As previously highlighted, the PPO tends to understate good work. A more positive approach, when things go well, really help to motivate staff to continue to perform at this level." (Prison – Other Governor)*

> *"Running with agendas and trying to make the reviews fit the agenda and case for change-such as with restraints. It feels that the PPO does not want any prisoners restrained when they are over 50 and being seen outside of the prison. (Clinical Reviewer)*

Finally an approach was suggested to maintain public confidence in the independence of the Ombudsman's office:

> *"Project a higher profile nationally / more effective publicity to assure wider public of independent role" (HM Inspectorate)*

7. Actions for the PPO

The actions from this survey have been captured in the PPO's business plan 2014-15, the stakeholder management plan 2014-15 and in individual staff Performance Management Record (PMR) objectives. Specifically we will:

- Continue to improve the timeliness of investigations
- Continue to ensure that reports are clear and concise and offer recommendations for improvement or learning
- Ensure that prison and healthcare staff are kept up to date when reports findings change
- Give reasonable notice to interviewees, including those in healthcare
- Continue building the Ombudsman's profile publically through continuing to publish the wider lessons learned from PPO investigations
- Continue to work with Coroners to share information
- Improve liaison – sharing messages and investigations outcomes with prison staff and healthcare managers where appropriate
- Increase communications, especially face to face contact with prison staff, to share messages and learning