Prisons & Probation Ombudsman
Independent Investigations

Annual Report 2016–17

Prisons & Probation Ombudsman

Annual Report 2016–17

Presented to Parliament by the Secretary of State for Justice
by Command of Her Majesty

July 2017

Cm 9461

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

PO Box 70769
London
SE1P 4XY

020 7633 4100
mail@ppo.gsi.gov.uk

You can download this publication from www.ppo.gov.uk

Contents

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 Services; the Home Office (Immigration Enforcement); the Youth Justice Board; 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 his office's Terms of Reference (ToR), the latest version of which can be found in the appendices.

The PPO has three main investigative duties:

- complaints made by prisoners, young people in detention,[1] offenders under probation supervision and immigration detainees
- deaths of prisoners, young people in detention, approved premises' residents and immigration detainees due to any cause
- using the PPO's discretionary powers, the investigation of deaths of recently released prisoners or detainees.

[1] The PPO investigates complaints from young people detained in secure training centres (STCs) and young offender institutions (YOIs). Its remit does not include complaints from children in secure children's homes (SCHs).

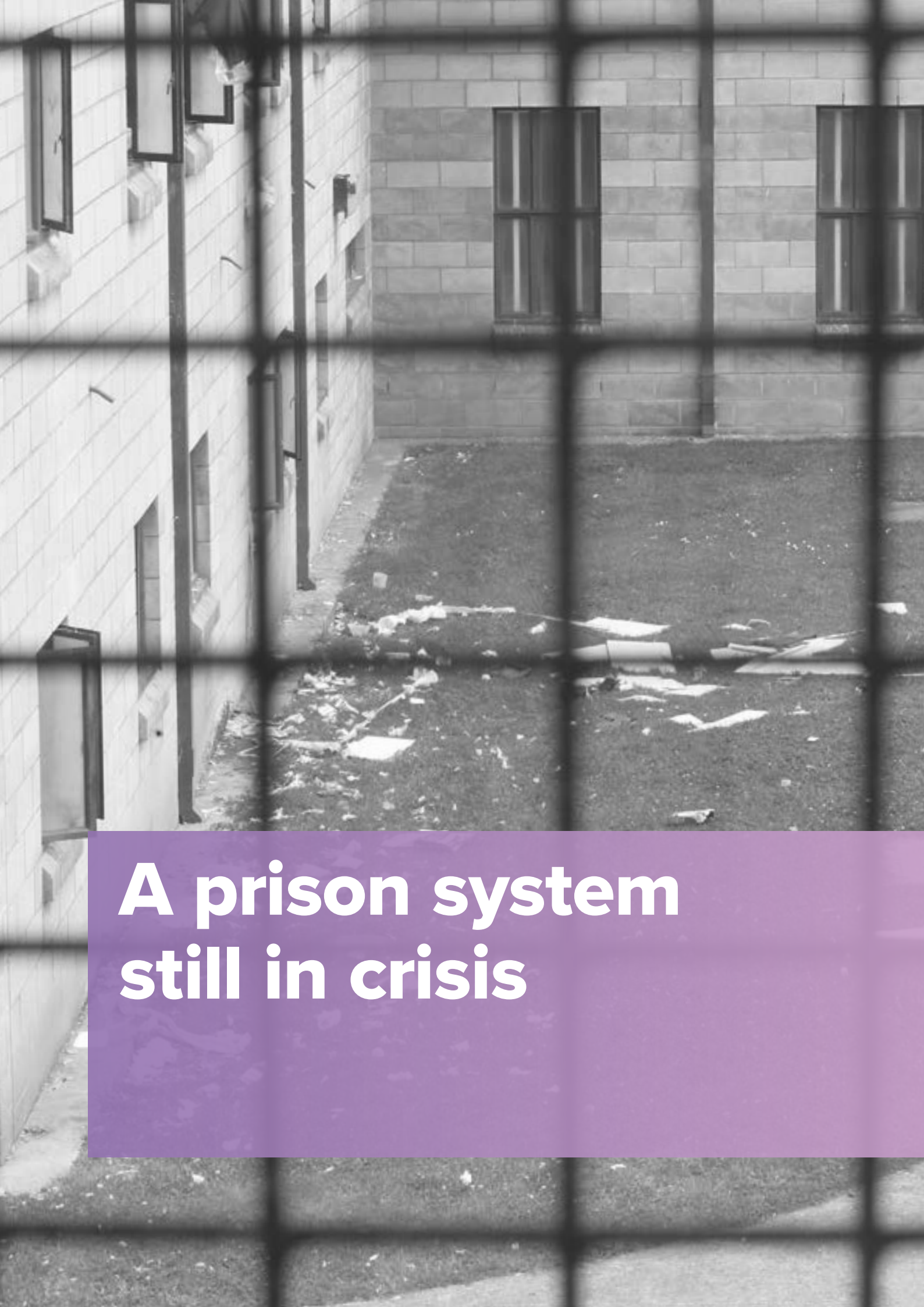
Our vision

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



A prison system still in crisis

This is my sixth and final annual report. I leave office shortly and do so with a mixture of pride in the efforts of my staff to contribute to safer, fairer custody, and sadness that I can report only limited improvement in prison safety and conditions over the past year.

On the one hand, I am delighted that this year my office won the first national civil service customer service award, on the other hand, this was in the face of an inexorable and mournful rise in demand. Self-inflicted deaths in custody rose 11%, other types of death rose 23% and eligible complaints rose 9%. These statistics, particularly when combined with high levels of violence[2] and incidents of significant disorder over the year, indicate a prison system still very much in crisis.

Fortunately, the previous Government recognised the need for reform and a range of changes to the prison system was begun, notably a reversal of some of the previous reduction in resources and an array of innovations. However, the problems are significant and systemic, and the previous Secretary of State was right to insist that improvement will take time. I would also argue that these reforms will founder unless they are underpinned by a transformation in prison safety.

One of the systemic failures is the apparent inability of prisons under pressure to learn lessons or to sustain improvement based on that learning. There is plenty of learning available, not least the copious amounts generated by my office. Individual investigations into deaths or complaints provide important individual route maps for particular establishments. And – in one of the key achievements of my time in post – there is now a substantial library of Prison and Probation Ombudsman's thematic learning. In short, it is not lack of knowledge, but a lack of effective action that is at issue.

> “In short, it is not lack of knowledge, but a lack of effective action that is at issue.”

[2] Ministry of Justice (2016) 'Safety in custody quarterly bulletin: December 2016', *Ministry of Justice Statistics Bulletin*. Online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/611187/safety-in-custody-statistics-q4-2016.pdf

The Government's reform programme must address this anomalous situation. My recommendations and thematic lessons rarely say anything new – I have been saying many of the same things for many years. Nor are prisons, or the other services I investigate, hostile or unsympathetic to what I have to say. Almost all my recommendations were accepted last year and an action plan put in place for their implementation. But, too frequently, my colleagues at Her Majesty's Inspectorate of Prisons – who, on their visits, routinely follow up on my fatal incident investigation recommendations – found that there had been a lack of action. Worse, my investigators were often called to new fatal incidents, only to find that previous lessons had not been learned – with tragic consequences.

This level of repeat failure must not be allowed to continue. As I leave office, I must hope that prisons and their hard-pressed staff can emerge from a uniquely challenging and dispiriting period and address the well-evidenced concerns of independent scrutiny bodies such as mine. Safety and fairness are touchstones of a civilised prison system and I know that my staff will continue to work hard to support these essential outcomes.

Self-inflicted deaths: still a rising toll of despair

Self-inflicted deaths rose 11% last year. While I welcome the fact that this rate of increase was less rapid than the 34% increase the year before, it was still unacceptably high. There was a depressing rise in self-inflicted deaths among women and even one tragic apparently self-inflicted death in my newest area of responsibility: secure children's homes.[3]

I do not think there is a simple, single explanation for these continued increases: each self-inflicted death is the tragic culmination of an individual crisis for which there can be a myriad of triggers, so we must redouble our preventive efforts on all fronts.

Of course, financial cutbacks, staff reductions and regime restrictions have reduced factors that protect against suicide and self-harm, such as activity, time out of cell and interaction with others. Many staff are also under severe pressure and caring for the vulnerable may require time that is all too scarce. However, the evidence linking austerity and death is inconsistent. For example, spikes in self-inflicted deaths have also occurred in high security prisons and the private prison estate, neither of which have had the level of cutbacks suffered elsewhere.

[3] We also opened an investigation into a second death at a secure children's home which was apparently due to natural causes.

Some major themes do emerge from my investigations that must be acted upon, for example the pervasiveness of mental ill-health and an epidemic of new psychoactive drugs, but whatever the explanation for the rise, self-inflicted deaths are just too prevalent in prison. In these complex circumstances, effective suicide prevention efforts are essential. Unfortunately, as the case studies in this report illustrate, too often my investigations identify repeated failings in these procedures.

I also remain concerned that current prison suicide prevention measures were designed when prisons had many fewer prisoners and many more staff. Despite some tinkering undertaken in response to concerns that I expressed in previous annual reports, suicide prevention procedures are still badly in need of updating and streamlining, without which I continue to question their fitness for purpose.

> “…suicide prevention procedures are still badly in need of updating and streamlining, without which I continue to question their fitness for purpose.”

Nevertheless, I pay tribute to the efforts of individual prison staff to support the vulnerable. My investigations rarely identify a fundamental lack of care or compassion among those who support the suicidal – although this year did see the criminal prosecution of at least one member of prison staff for dereliction of duty in this regard. However, too frequently, I do find failures of management, weak procedures, poor information sharing, a lack of joined up working, gaps in training and poor emergency responses. Only by systematically addressing these failings will we stem the rising toll of despair in prisons.

Still no sense of direction for work with older prisoners

Unlike the rise in self-inflicted deaths, the reason for the even sharper (19%) increase in deaths from natural causes is largely explained by the age-related ill health that attends a rapidly ageing prison population.[4] This demographic shift has been dramatic, driven by increased sentence length and more late in life prosecutions for historic sex offences. As a result, the number of prisoners over 60 has tripled in 15 years and is now the fastest growing segment of the prison population.[5] The projections are all upwards and there are expected to be approximately 14,000 prisoners over 50 by June 2020.[6]

The challenge to the Prison and Probation Service is clear: prisons designed for fit, young men must adjust to the largely unexpected and unplanned roles of care home and even hospice. Increasingly, prison staff are having to manage not just ageing prisoners and their age-related conditions, but also the end of prisoners' lives and death itself – usually with limited resources and no training.

"Increasingly, prison staff are having to manage not just ageing prisoners and their age-related conditions, but also the end of prisoners' lives and death itself."

Unfortunately, there has been little strategic grip of this sharp demographic change. Prisons and their healthcare partners have largely been left to respond in a piecemeal fashion. The inevitable result, illustrated in many of my investigations, is variable end of life care for prisoners and limited support for staff. In addition, my investigations continue to expose the inability of some prisons to adjust their security arrangements appropriately to the needs of the seriously ill. For example, it is unacceptable that I still find too many examples of prisons unnecessarily and inhumanely shackling the terminally ill – even to the point of death.

[4] Prisons and Probation Ombudsman (2017) *Older Prisoners*, London: PPO.

[5] Data taken from Allen, G. and Dempsey, N. (2016) 'Prison Population Statistics', *House of Commons Library Briefing Paper SN/SG/04334*. Full report online at: http://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN04334#fullreport

[6] Ministry of Justice (2006) 'Prison Population Projections 2016-2021, England and Wales', *Ministry of Justice Statistics Bulletin*. Online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/548044/prison-population-projections-2016-2021_FINAL.pdf

However, I must add that, over the past year, I have also seen examples of impressively humane care for the dying by individual prison staff, as well as glimpses of improved social care and the development of some excellent palliative healthcare services – but the picture is unacceptably inconsistent and progress too slow.

Above all, I remain astonished that there is still no properly resourced older prisoner strategy, to drive consistent provision across prisons. This is something I have called for repeatedly and without which I fear my office will simply continue to expose unacceptable examples of poor care of the elderly and dying in prison.

Still too much to complain about

The ability to complain effectively is integral to a legitimate and civilised prison system. A meaningful internal complaint process, overseen by an independent adjudicator such as my office, is an important means for prisoners to ventilate grievances legitimately. It can also help avoid illegitimate explosions of anger about perceived failings, which have been all too common in prisons in the past year. Unfortunately, while many reasons to complain remain, the processes for doing so are often poor and prisoner confidence in the complaint process is low. This is a toxic combination.

“The ability to complain effectively is integral to a legitimate and civilised prison system.”

Prison reform may be underway, but the challenges facing the penal system remain. The typical experience for many prisoners is still one of crowding, lack of safety, limited activity and an over-stretched staff struggling to meet need. While there may be scant public sympathy, prisoners’ legitimate expectations are often not being met. This is reflected in a 9% increase in eligible complaints to my office last year.

In a further sign of these strains, the proportion of complaints I upheld last year because prisons got things wrong, remains much higher than when I took office. In 2016–17, 39%[7] of complaints by prisoners were upheld, compared to only 23% in 2011–12. This is not about my staff becoming more sympathetic, but reflects prison staff making more mistakes, not learning lessons from my previous investigations and – crucially – not resolving issues at a local level.

[7] This figure relates solely to prison complaints and excludes those related to probation services or immigration removal centres. When looking across all complaint types my office has found in favour of the complainant in 38% of cases.

Many of the complaints reaching my office need never have been escalated to us. Instead, they should have been resolved at source by an effective local complaints process. When prisons fail to manage complaints effectively, it leads to frustration for prisoners, places additional burdens on staff and uses up my scarce resources, which could be better deployed on more serious or complex cases. The prison reform agenda needs to include a requirement on each prison to have a fully functioning complaints process.

“When prisons fail to manage complaints effectively, it leads to frustration for prisoners, places additional burdens on staff and uses up my scarce resources, which could be better deployed on more serious or complex cases.”

Nor is it only prison complaint processes that need to improve. A number of Community Rehabilitation Companies have failed to ensure an effective complaints process for offenders in the community, despite this being a contractual obligation, which is something I have raised with the Chief Executive of HM Prison and Probation Service.

Ministers will also need to require that reforms which give greater autonomy to prison governors, are appropriately balanced by clear statements of national minimum entitlements for prisoners. As I argued in last year’s annual report, without clarity as to these minimum standards and how they are to be adhered to, prisoners’ legitimate expectations may be dashed, inappropriate disparity between prisons entrenched, confrontation made more likely, engagement in rehabilitation undermined and independent dispute mechanisms like my office (and the courts) flooded with even more complaints. This warning, as yet, remains unheeded.

Meanwhile, I pay tribute to my complaint investigators who continue to respond with care and thought to the incessant demand and enormous array of issues that arrive on their desks. The case studies in this report illustrate this range, from the day-to-day frustrations of prison life to serious allegations of abuse. All must be dealt with fairly and objectively. In many cases, all parties can be encouraged to agree an appropriate outcome, in other cases the unreasonable expectations of prisoners must remain unsatisfied, while in still other cases, staff must be held to account for serious failings – but, in all cases, we seek to ensure a fair and just outcome.

The learning is there, now use it

I am immensely proud that I have been able to deliver on my commitment to the Justice Select Committee, when they confirmed my appointment, that I would create a library of thematic learning to complement our individual investigation reports. Since 2012, there have been nearly 40 publications designed to distil learning from investigations and support the organisations in remit to improve safety and fairness.

“Since 2012, there have been nearly 40 publications designed to distil learning from investigations and support the organisations in remit to improve safety and fairness.”

This year there were six learning lessons publications. Two provided important analyses of how prisons should respond to violence. One of these set out lessons from our – mercifully rare – investigations into homicide in prison. Another provided lessons to minimise the inappropriate use of force by an embattled staff having to deal with escalating rates of assault. Other bulletins looked at how to support particularly vulnerable populations: children, transgender prisoners and elderly prisoners with dementia. The year’s final bulletin identified lessons to reduce the awful increase in self-inflicted deaths of female prisoners.

These publications have been well received but their value relies on custodial and probation staff actually implementing the learning. We continue to explore new ways of disseminating this learning and making it accessible, for example, by supplementing our publications with articles, leaflets, posters and forays into social media. We also held our third annual series of learning lessons seminars for operational staff, which were very well attended and, I hope, encouraged the practical implementation of our learning.

Still delivering more for less

The incessant growth in demand for my office's services has, inevitably in these austere times, not been accompanied by any increase in resources. Indeed, my budget was actually cut by 4.6% and this is not sustainable when demand continues to soar. This has, of course placed a great strain on my staff, to whom I pay tribute for their sustained and impressive performance.

It is a remarkable achievement that, despite many more cases to investigate, almost every fatal incident draft report was on time last year. When I arrived in 2011, 86% of reports were late, even though there were far fewer investigations and more resources. Moreover, our stakeholder and bereaved family surveys confirm that that it is not just the timeliness, but also the quality of our investigations that is appreciated. It is gratifying that this performance was recognised by the 2016 national civil service award for customer service.

> “It is gratifying that this performance was recognised by the 2016 national civil service award for customer service.”

Performance of my complaint investigation staff has also been impressive. Assessment of complaints last year exceeded our timeliness target and historic backlogs of investigations have been eradicated. However, demand far outstripped supply, so pressures on us inevitably remain, particularly in terms of investigation timeliness. Nevertheless, the contribution that my staff make to supporting fairness and justice in custody and for offenders on supervision in the community, is well recognised, as illustrated by our stakeholder and complainant surveys.

The Ombudsman still needs better legal powers

Finally, I was grateful that previous Ministers acted on my repeated requests and began the process of placing my office on a statutory footing. Sadly, the Prison and Courts Reform Bill could not proceed once the general election was called. Its provisions would have made a substantive difference to the actual and visible independence of the Prisons and Probation Ombudsman and given my successor important practical protections. I can only hope legislative space will be found to reintroduce the provisions in the new Parliament.

Even without this long awaited legal underpinning, readers of this annual report should be left in no doubt of my independence of mind or that of my staff and our unwavering commitment to support improved safety and fairness in custody and for offenders being supervised in the community.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

The year in figures

Fatal incidents

- In 2016–17, we started investigations into **361 deaths**, a **19% increase** on the previous year. The majority of these deaths were of prisoners **(94%)**.
- We began investigations into **208 deaths** from natural causes, **19% more** than last year.
- We began **11% (115)** more investigations into self-inflicted deaths, a further increase on last year's record number of self-inflicted deaths and **nearly a 50% increase in two years**.
- We began investigations into **11 deaths** of residents living in probation approved premises, a slight decrease from **12** last year.
- In 2016–17, we began **3** investigations into deaths of immigration removal estate residents, the same figure as the previous year.
- In 2016, the PPO's remit was extended to include fatal incidents in secure children's homes. Sadly, in 2016–17, we have already started investigations into the deaths of **2** children.
- We began investigations into **4** apparent homicides, a decrease from **6** in 2015–16.
- In 2016–17, we were notified of **16 deaths** which were 'other non-natural', **9** relating to drug toxicity.
- In 2016–17, we made **690 recommendations** following deaths in custody – **22% (151)** of these were related to healthcare provision, **14% (100)** to emergency response, **11% (79)** to suicide and self-harm prevention and **11% (76)** to escorts and restraints.
- We issued **324 initial reports** and **322 final reports** compared to **284** and **261** the previous year.
- Despite our increased caseload we have worked hard to maintain our timeliness performance. This year we issued **100% of initial fatal incident reports** and **87% of final reports** on time.
- The average time taken to produce reports remained the same as last year with initial reports for natural cause deaths taking **18 weeks** and reports on all other deaths taking **24 weeks**.

Draft reports issued

324 2016–17

284 2015–16

Draft reports issued on time

100% 2016–17

100% 2015–16

Total deaths

361 2016-17

304 2015-16

19% Increase

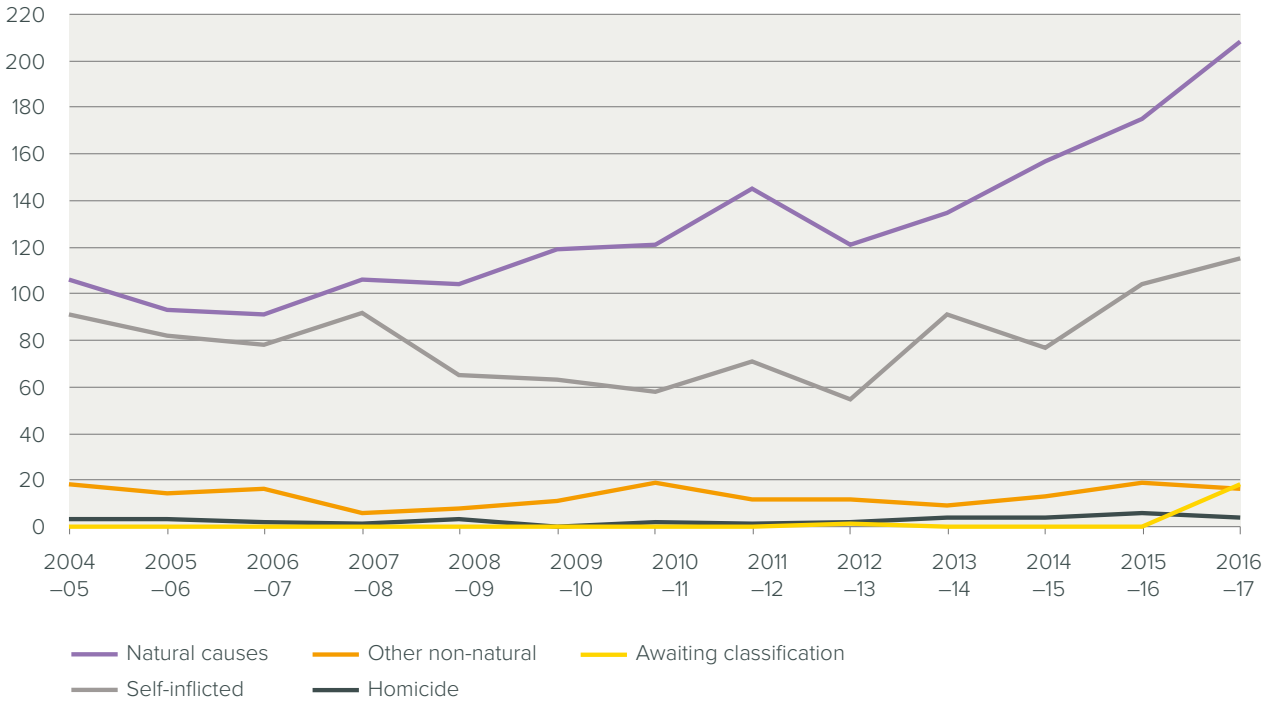
Total self-inflicted deaths

115 2016–17

104 2015-16

11% Increase

Fatal incident investigations



Complaints

- This year we received **5,010 complaints**, a **5% increase** on the previous year and we made 5,005 eligibility assessments.
- Our caseloads increased by **9%** in 2016–17. We started investigations into **2,568 cases** compared to **2,357 cases** in 2015–16.
- In order to appropriately allocate resources, we do not investigate all cases that are eligible if it is considered that they do not raise a substantive issue or there is no worthwhile outcome. In 2016–17, we declined to investigate **415 cases** on this basis, a decrease of **31 cases** from the previous year.
- In 2016–17, there were **38 complaints** accepted for investigation but withdrawn by the Ombudsman as a result of a change in circumstances. A further **32 cases** were withdrawn by the complainants.
- In 2016–17, we completed **2,313 investigations**, **23 cases** more than 2015–16.
- We worked hard to prevent a backlog of cases waiting to be assessed and improved our timeliness of responding to complainants. This year we assessed **82% of cases** within time, compared to only **50% of cases** in 2015–16.
- Complaints from high security prisons continued to account for a disproportionate number of complaints we investigated. They accounted for **29%** of our completed investigations yet made up **7%** of the prison population.
- Complaints completed about the high security estate were less likely to be upheld. We found in favour of complainants from the high security estate **33%** of the time compared to **41%** from other prisons.
- We received **38 complaints** about immigration removal centres, **20** fewer than the previous year.
- The number of probation complaints we received also decreased from **323** to **315**.
- The most common category of prison complaints completed related to property; it accounted for **29%** of the investigations we completed. The next most common category was administration (**12%)** and complaints related to staff behaviour (**8%**).
- This year we found in favour of the complainant **38%** of the time, compared with **40%** the previous year.
- The increase in caseload had an impact on our timeliness. We completed **32% of investigations** within time this year compared to **39% of investigations** in 2015–16.

Complaints received

5,010 2016–17

4,781 2015–16

Investigations started

2,568 2016–17

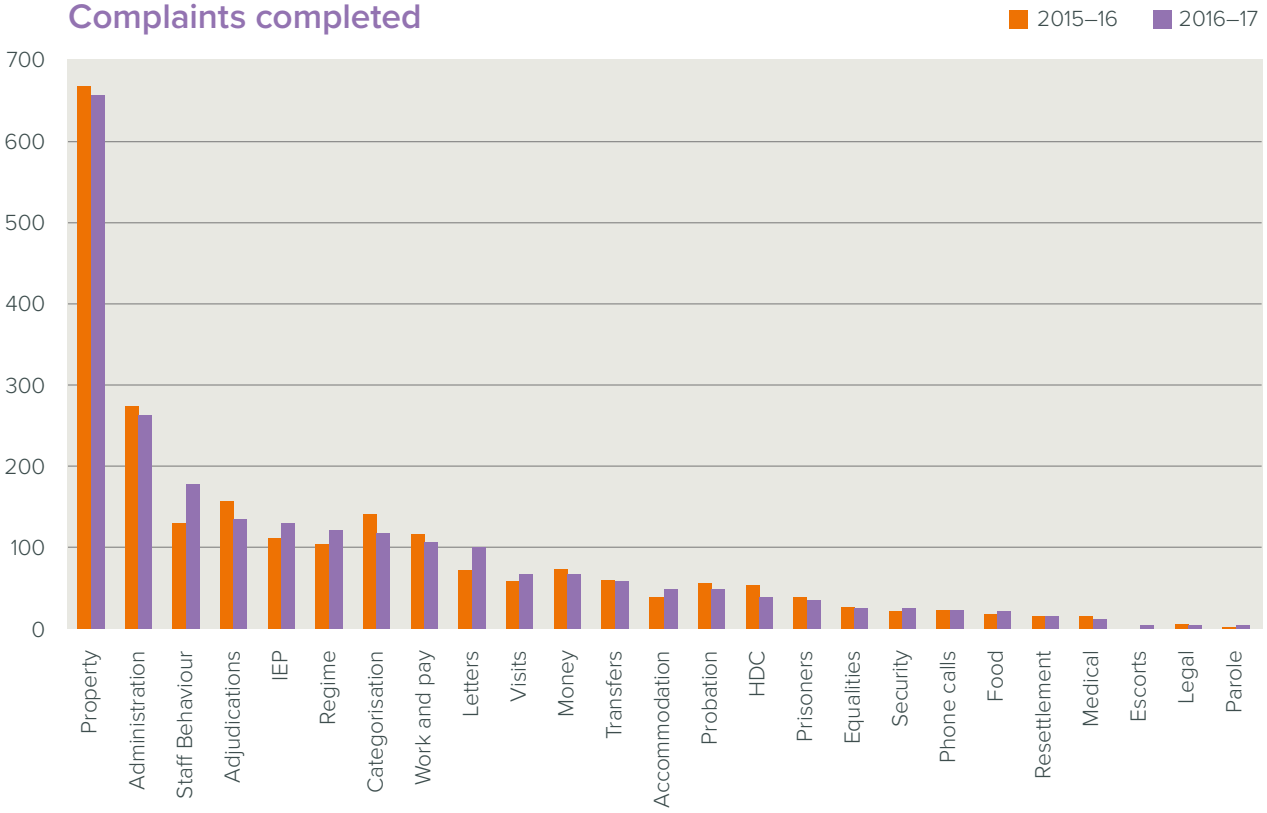
2,357 2015–16

Investigations completed

2,313 2016–17

2,290 2015–16

Complaints completed



Investigating fatal incidents

Self-inflicted deaths

The sharp and troubling rise in deaths in custody noted in last year's annual report continued with an 11% increase in self-inflicted deaths and a 19% increase in deaths from natural causes. There remains no single straightforward explanation for the continuing rise in self-inflicted deaths. The following case studies set out areas where we have seen significant numbers of self-inflicted deaths and where our investigations made recommendations whose implementation should help avoid deaths or improve care in the future.

Faced with the relentless increase in suicides, the Prison and Probation Service has, rightly, begun to refresh its approach to the management of suicide and self-harm, which is urgently needed. It is particularly troubling that 11% of all of our recommendations are related to the effective delivery of suicide and self-harm prevention measures (known as ACCT). We remain concerned that ACCT was designed for a prison system that had far fewer prisoners and many more staff. Too often, staff tell us that the procedures cannot be properly resourced. These concerns need thorough review, so that there is assurance that ACCT remains fully fit for purpose.

"We remain concerned that ACCT was designed for a prison system that had far fewer prisoners and many more staff."

ACCT and assessment of risk

The ACCT process relies on the good use of all available information to determine a prisoner's risk. Used properly, it should provide the framework to assess and support prisoners at risk of suicide or self-harm. The increase of self-inflicted deaths demonstrates that lessons still need to be learned.

Our investigations into self-inflicted deaths routinely acknowledge that the identification and management of prisoners' risk of suicide or self-harm relies on staff using their experience and skills, as well as local and national assessment tools. Yet all too often, staff place too much emphasis on how a prisoner seems during their brief contact. A prisoner's presentation is obviously important and reveals something of their level of risk, but staff should make a considered, objective evaluation of all other risk factors for suicide and self-harm and document their evaluation. This is particularly important when it is the prisoner's first time in prison.

The following case studies illustrate staff failing to take account of valuable information about prisoners they had never met before, and being persuaded by a prisoner's presentation, as opposed to documented risk. The studies show the need for multidisciplinary input throughout the ACCT process and the need for effective and flexible use of resources. They underpin our concerns about the overall effectiveness of the ACCT process in the current operational environment.

When Mr A was arrested for an alleged offence against a family member, he held a pitchfork against his abdomen and said he wanted to die. He told the police he would kill himself after he was released. A court officer completed a suicide and self-harm warning form and staff checked on Mr A six times an hour while he was in the court cells.

A court caseworker recorded that Mr A had told her he had last tried to harm himself two days before and was having suicidal thoughts. He had depression and had been prescribed medication. This was the first time he had been sentenced to prison. She passed all this information to the prison, including his previous suicide attempts, and prison staff began suicide and self-harm prevention procedures.

A prison manager had to decide what actions were needed to keep Mr A safe in his first hours at the prison, but she did not read any of the documents that arrived with him. On the basis of what Mr A said to her and how he appeared, she decided that staff should check him once an hour at irregular intervals. She did not consider him to be at a high risk of suicide or self-harm. Less than three hours after being allocated to a single cell in the first night centre, an officer found Mr A hanging.

As seen in this case study, all risk factors need to be considered to ensure that a prisoner's level of risk is judged holistically. Over-reliance on a prisoner's presentation can prevent staff from considering other aspects of their risk and from using all the information available to them. If a prisoner's level of risk is then underestimated, insufficient support measures may be put in place to manage it adequately.

> "Over-reliance on a prisoner's presentation can prevent staff from considering other aspects of their risk and from using all the information available to them."

When Mr B arrived at prison, reception staff noted that he had previously tried to hang himself in custody and appropriately started suicide prevention monitoring procedures. However, his ACCT assessment was held nearly a day late and healthcare staff did not attend the case reviews, which were also held later than required. The plan to manage Mr B's risk overlooked key risk factors identified in his assessment, such as his mental health and impulsivity, and the case manager underestimated Mr B's level of risk. ACCT checks were limited to regular observations, rather than irregular meaningful interactions, as required by ACCT policy. After less than two weeks, officers assessed Mr B as no longer being at risk and stopped monitoring him, without any input from the mental health team.

Less than a week later, Mr B told an occupational therapist that he could not stop thinking about suicide, so ACCT monitoring procedures were started again. A few days later, Mr B told officers that he was thinking of killing himself that evening. Officers emailed Mr B's ACCT case manager twice, suggesting that Mr B's observations should increase in line with his heightened risk. The case manager did not hold a multidisciplinary meeting to discuss this, or increase Mr B's observations in light of officers' concerns, so staff continued to manage Mr B as if he were at low risk of suicide. Three days later Mr B was found hanged in his cell.

Multidisciplinary team working is essential for the holistic management of risk. The caremap is a fundamental tool to address a prisoner's main risks and needs, and to identify what can be done to help. It has to include expertise from the range of professionals working across the prison. For all those assessed as being at risk of suicide or self-harm, there should be regular multidisciplinary review meetings to evaluate and assess progress against the caremap. Repeatedly, we find review meetings are held by solitary members of staff or without crucial input from healthcare or other staff. Such poor reviews fail to appropriately identify a prisoner's risks and how to address them. In Mr B's case, our investigation found that prison staff could have managed his risk more effectively through better use of ACCT procedures.

It is not for our investigations to make judgements on the resourcing of prisons but we have found that staff at all levels are struggling to manage the detailed and prescribed levels of interaction, recording and evaluation set out in the ACCT process. They are often managing numerous prisoners on busy and demanding wings, while at the same time, managers are focused on attempting to deliver the broader prison regime.

When we do make critical findings, in cases such as Mr B's, our investigators are often told that we have set an unachievable standard for hard-pressed staff and that our judgements are unfair. That is not our intention – we set out to comment on whether the agreed, prescribed and specific requirements set out in the ACCT process are met, and when they are not, we say so. It is against this uncomfortable background that we describe the frequent shortcomings in the management of those at risk of suicide and self-harm.

Early days in custody

Prisoners are particularly vulnerable during their early days in custody and are at increased risk of suicide and self-harm during this difficult and daunting period.[8] We have continued to investigate deaths where reception staff have not identified a prisoner's risk factors or, if they have, have placed too much weight on how the prisoner seems or their assurance that they have no thoughts of suicide. In order to assess risk properly, reception staff are required to examine all relevant information, including a prisoner's Person Escort Record (which accompanies them between court and prison). It is critical that reception and induction staff, not only promptly start ACCT monitoring for newly arrived prisoners at risk, but also that they put in place appropriate support, decide how frequent observations should be and how long ACCT procedures should be kept open, all taking into account a prisoner's individual risk factors.

> "Prisoners are particularly vulnerable during their early days in custody and are at increased risk of suicide and self-harm during this difficult and daunting period."

Mr C died two days after he arrived in prison. He had spent time in prison before but had never been identified as at risk of suicide or self-harm. Mr C tested positive for illicit drugs, including opiates. Unlike English prisons, Welsh prisons do not offer an integrated drug treatment system for prisoners who arrive dependent on substances, and they do not routinely offer opiate medication for maintenance or detoxification. A nurse gave Mr C non-opiate symptom relief as he had not received a prescription for opiates in the community. The day after he arrived, staff started ACCT monitoring after he told them he had suicidal thoughts and that he had tried to hang himself recently. Officers put Mr C in a cell with a friend and checked him once an hour. Mr C refused to take part in the assessment and review of his risk. Mr C reportedly obtained and took subutex, an opiate substitute, from other prisoners. Two days after he arrived, Mr C's cellmate found him hanged in their cell. Staff and paramedics were unable to resuscitate him.

[8] Prisons and Probation Ombudsman (2016) Early days and weeks in custody. London: PPO.

Staff observed Mr C at predictable hourly intervals. When Mr C refused to take part in his ACCT assessment, staff should have used all available information to identify issues affecting Mr C's risk. No one reviewed his risk or discussed how to reduce it. Although nurses gave Mr C medication to help with withdrawal symptoms, Healthcare Inspectorate Wales concluded that the care Mr C received for opiate detoxification was not equivalent to that he would have received in the community where he would most likely have had access to opiate medication for withdrawal or stabilisation.

Mr D died eight days after he arrived in prison on remand. It was not his first time in prison and he had a history of suicide and self-harm. Staff considered his risk factors and concluded that he was not at risk. The evening he arrived, Mr D tried to hang himself in his cell. He was unhappy that he could not smoke as it was a non-smoking prison. They moved him to the supportive environment of the social care unit. He threatened to kill himself if he was not given an e-cigarette. Mr D was assessed as high risk and placed under constant supervision under ACCT procedures. Two days after he arrived, a senior manager agreed that Mr D's risk had lowered and reduced the frequency of his observations to at least once an hour. Officers suggested that Mr D should work and move to a standard wing. The next day, Mr D was found hanged in his cell.

While staff appropriately considered Mr D's risk, when deciding to reduce his observations two days after he first tried to kill himself, they placed too much emphasis on his location, rather than his underlying risk. Mr D received appropriate drug and alcohol detoxification but there was a delay in Mr D receiving previously prescribed antidepressants. Mr D appeared to struggle to cope in a smoke-free prison and linked his self-harm to not being able to have an e-cigarette. Mr D did not receive smoking cessation help and staff did not support him in dealing with his addiction to cigarettes.

Segregation

Segregation units are used to keep some prisoners apart from others. This is normally because they are vulnerable or under threat from other prisoners, or because they behave in a way that prison staff think might endanger others or cause problems for the rest of the prison. Segregation unit regimes are restrictive and prisoners usually spend most of their time alone in their cell, only allowed to leave for short periods to wash, collect meals, make telephone calls or spend time in the open air.

Our investigations into deaths of prisoners held in segregation units showed that often, some of the most challenging prisoners are also the most vulnerable.[9] This is hugely difficult for staff to manage, but it is essential that prisons recognise that the restrictive and isolating regimes in segregation units can accelerate deteriorations in a prisoner's mental and physical health, their risk to self and behaviour.

> "...it is essential that prisons recognise that the restrictive and isolating regimes in segregation units can accelerate deteriorations in a prisoner's mental and physical health."

There are a number of rules about segregating prisoners properly and humanely, which prison staff are required to follow. Unfortunately, our investigations of deaths in segregation units often found that staff did not always follow, or even know about national instructions, including that prisoners at risk of suicide should only be segregated in exceptional circumstances, once all other possibilities have been discounted. As in the case of Mr E, staff do not always consider other options or record their reasons for acting exceptionally.

Mr E was a foreign national prisoner with a history of self-harming. While being monitored under ACCT procedures, he attacked an officer and was moved to the prison's segregation unit. No one recorded the exceptional reasons for segregating him while under ACCT procedures. In the segregation unit, Mr E's behaviour deteriorated significantly and swiftly. He refused medication, food and fluids, he would not let healthcare staff review him and he became violent. He covered himself and his cell with food and faeces. Mr E smashed his cell furniture and staff removed it all from the cell, effectively leaving him in an unfurnished cell. Contrary to national instructions, staff did not hold an enhanced case review with managers from relevant departments. Mental health staff decided that Mr E's mental health would not deteriorate if he continued to be segregated, but segregation unit staff became concerned that the segregation unit was not the right environment for Mr E.

[9] Prisons and Probation Ombudsman (2015) *Segregation*. London: PPO.

A psychiatrist assessed Mr E and recommended he be moved to a prison with 24-hour healthcare. The prison could not find a suitable inpatient bed for him. Mr E continued to eat and drink little. Later, a nurse checked his blood glucose levels, which were high, but they took no further action. Mr E lost weight but refused to engage with healthcare staff. Eventually, healthcare staff became concerned about Mr E and while they were examining him, he deteriorated and staff called an ambulance. Hospital staff concluded that Mr E did not have the mental capacity to refuse treatment, so he was sedated, moved to intensive care and treated. Mr E died in hospital as a result of complications from pneumonia and acute dehydration.

The Prison Service Instruction covering safer custody[10] expects ACCT case reviews to be multidisciplinary where possible, and there is a mandatory requirement that healthcare staff attend the first case review. In Mr E's case, healthcare staff, and particularly mental health staff, were not sufficiently involved in the ACCT process.

The instruction also notes that prisoners whose behaviour is particularly challenging and disruptive should be managed under an enhanced ACCT case management process. Mr E's behaviour was so challenging that the enhanced case management process, designed to ensure the involvement of more senior staff and relevant specialists, would have been appropriate. We found no evidence in this case that staff had considered using the enhanced case management process.

[10] PSI 64/2011 (Management of prisoners at risk of harm to self, to others and from others).

Mr F received an indeterminate prison sentence for public protection with a minimum period to serve of four years. However, he was never considered suitable for release, which left him very frustrated. He was transferred to a new prison where he harmed himself, set fire to his cell, threatened staff and demanded to move to the segregation unit. Staff began ACCT procedures and moved him to the segregation unit. A supervising officer held the first ACCT review alone the next morning, contrary to national instructions. He did not record the exceptional reasons for segregating a prisoner assessed as at risk of suicide and self-harm, or that he had considered alternative accommodation.

Managers later agreed that Mr F should be held in an unfurnished cell to manage his risk. No one assessed his mental health or held an enhanced ACCT case review, as Prison Service Instructions require. The next day, Mr F returned to a standard segregation cell but, after threatening staff with weapons, was moved back to an unfurnished cell. Mental health staff tried to assess Mr F, but he was considered too volatile and dangerous to speak to. Mr F was moved back to a standard segregation cell. That evening, an officer checked on Mr F and found him with a ligature around his neck. Mr F died in hospital, having never regained consciousness.

As in Mr E's case, Mr F's behaviour was particularly challenging and disruptive and should have been managed under an enhanced ACCT case management process and it was disappointing that we found no evidence that staff had even considered it.

"As in Mr E's case, Mr F's behaviour was particularly challenging and disruptive and should have been managed under an enhanced ACCT case management process and it was disappointing that we found no evidence that staff had even considered it."

Mental health

Many prisoners whose cases we investigated in 2016–17 suffered from significant mental health issues. Our investigations continued to identify the same issues set out in our 2016 learning lessons bulletin *Prisoner Mental Health*,[11] in particular, challenges in identifying prisoners' needs, accessing appropriate services to manage those needs, prisons taking punitive rather than therapeutic action in response to challenging behaviour, and setting inappropriate care plans which were not meaningful, reviewed or updated. The following case studies provide evidence of some of these challenges.

> “Many prisoners whose cases we investigated in 2016–17 suffered from significant mental health issues.”

Following a rapid deterioration in his mental health, Mr G was sectioned under the Mental Health Act and released into the care of his family. He then stabbed his brother and his father before trying to stab himself. He was charged with two counts of attempted murder and was remanded into custody. The prison was informed that Mr G was at high risk of suicide and it was expected that he would be transferred to a secure hospital. He was admitted to the prison's inpatient unit and kept under constant supervision. Three days later, staff reduced the level of observations to two an hour but no clinician was involved in the decision. A psychiatrist assessed Mr G but did not complete the recommendation for transfer. Despite still recognising that Mr G remained at a high risk of suicide, formal monitoring was kept to only two observations per hour. The formal recommendation for Mr G's transfer to a secure hospital was only completed two weeks after his arrival.

Mr G asked to speak to members of his family several times but was unable to remember their phone numbers and staff did little to assist. Family members visited Mr G in prison and called the prison on several occasions because they were concerned, and felt he might try to kill himself. He continued to behave in a paranoid manner and the day before he died, showed a mental health nurse some scratches he had made on his arms. No investigation or discussion took place about his increased risk. The next day Mr G was found electrocuted in his cell.

[11] Prisons and Probation Ombudsman (2016) *Prisoner mental health*. London: PPO.

Our investigation found that staff did not take sufficient account of Mr G's significant underlying risk factors for suicide when making an assessment and setting his level of observations. There was no clinical input into the decision to reduce the level of observations. His caremap was not updated and reviewed at each case review. There was not enough focus on how to reduce his risk, such as facilitating family contact, and too little was done to involve Mr G's family in his care or to respond to their concerns. Observations were at regular and predictable intervals and a mental health nurse took insufficient action when Mr G cut his arms. Prison healthcare staff did not properly understand the process for transferring Mr G to hospital under the Mental Health Act, and missed an early opportunity for a transfer. Mr G was acutely mentally ill and, while all those involved in his care agreed that prison was not an appropriate place for him, systems designed to divert him to hospital did not operate effectively.

"Mr G was acutely mentally ill and, while all those involved in his care agreed that prison was not an appropriate place for him, systems designed to divert him to hospital did not operate effectively."

Mr H had a history of mental health problems. He had been diagnosed with a personality disorder and suffered from depression. He had tried to take his life a number of times before and had only been discharged from hospital (after taking an overdose) the day before he arrived in prison for the first time.

Despite this, and other significant risk factors, no one identified Mr H as being at risk of suicide. However, he was housed in the prison's support and mentoring unit, which gives additional help and support for new and vulnerable prisoners in their first weeks at the prison. Some weeks later, he was monitored under ACCT procedures for a fortnight but these procedures did not operate fully effectively. Mr H appears to have settled at the prison. He had a job in the laundry, was supported by a mentor and had friends on his wing. Staff did not identify any concerns and he did not self-harm. Although he was treated for depression and sometimes said his mood was low, staff did not subsequently consider monitoring his risk of suicide or self-harm. However, one morning, Mr H was found hanged in his cell.

Despite a number of significant risk factors when Mr H arrived at the prison, no one identified them properly. Although he was monitored under ACCT procedures for two weeks, none of the case reviews were multidisciplinary and they did not include relevant people involved in his care. It is evident that Mr H always had a long-term risk of suicide, and continued to suffer from depression even though he appeared to have settled at the prison. Despite him saying that he intended to kill himself after he was released from prison there was little to indicate that he was at imminent and high risk at the time of his death.

While it would have been difficult to have foreseen or prevented Mr H's actions, he did not receive the type of mental health support and interventions he needed. There were delays responding to mental health referrals and services available for prisoners with personality disorders were not adequate. Mr H received some good support from a mentor, other prisoners on his wing, and staff from the substance misuse team, but there was little evidence of engagement with his personal officer or other wing staff.

Drugs

Drugs, and in particular new psychoactive substances (NPS), continue to present a significant problem across the prison estate. Narrowly, the effects of NPS vary, depending on the strength of the drug, the amount taken, the circumstances of the individual and the environment in which they take the drug. NPS are difficult to detect and can affect people in a number of ways, including increased heart rate, raised blood pressure, reduced blood supply to the heart and vomiting. Prisoners under their influence can also display marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence.

“Drugs, and in particular new psychoactive substances (NPS), continue to present a significant problem across the prison estate.”

NPS have been described as a 'game changer' by the Ombudsman, given their impact on the prison environment. Besides the clear and emerging evidence of dangers to physical health, increased availability of NPS within prisons has reduced safety, with the potential for precipitating or exacerbating the deterioration of mental health.

The number of prisoner deaths where the use of NPS may have played a part, continued to rise. Although the links between NPS and these deaths were not necessarily immediately apparent or causal, they cannot be discounted. Their impact on the rising numbers of suicides, deaths from drug toxicity, apparent natural causes and even homicides, cannot be overstated. In particular, our investigations suggest that the use of NPS, like other drugs, can be closely associated with organised crime, debt, bullying and violence, with attendant risks to vulnerable prisoners, of mental ill-health, suicide and self-harm.

There is a greater need than ever, for more effective drug supply and demand reduction strategies, including better monitoring by drug treatment services and effective violence reduction strategies. Prisons must increase staff awareness and training; governors need to robustly address the bullying and debt associated with NPS; and demand for NPS among prisoners needs to be reduced, with prisons and healthcare providers ensuring that there are engaging education programmes for prisoners which outline the risks of using them.[12]

“
...demand for NPS among prisoners needs to be reduced, with prisons and healthcare providers ensuring that there are engaging education programmes for prisoners which outline the risks of using them.”

[12] Prisons and Probation Ombudsman (2015) *New psychoactive substances*. London: PPO.

Mr I had been released from prison on licence but was recalled to custody because of inappropriate behaviour after taking NPS. He tested positive for benzodiazepines and opiates in reception, and was referred to the substance misuse team. He later collapsed in his cell, having had 'a spice (or NPS) attack', but refused to allow paramedics to examine him and the incident was not recorded in his medical record. Two months later, Mr I was found collapsed in his cell. An ambulance was called but before it arrived, Mr I got up and began walking around, muttering. Staff believed his behaviour was indicative of his having taken NPS but decided that the ambulance was no longer needed and placed him under half-hourly observations instead. The last observation was at 8.30pm and Mr I was found dead in his cell the following morning. A post-mortem examination found that he had died of sudden adult death syndrome but toxicology results found NPS present in his bloodstream.

Although the post-mortem did not attribute Mr I's death directly or indirectly to substance abuse, Mr I had a significant history of substance misuse, including NPS. The prison showed no strategic approach to the management or monitoring of his suspected use of NPS, and no support systems were in place. In addition, there was no evidence of prison and healthcare staff taking a coordinated approach to reduce the supply of and demand for NPS within the prison, and therefore reducing its associated risks.

Women prisoners

Levels of self-harm among women prisoners have been consistently high over recent years, yet historically, the number of women who take their lives in prison has been small compared to the number of men.[13] Tragically, this reporting year has seen a sudden increase in the number of deaths of women in prison; this has risen to 23 deaths in 2016–17. Although a number of these deaths were drug-related, there was a troubling number of self-inflicted deaths, with 11 female prisoners taking their own lives. Some of the themes arising from these women's deaths were reflected in the learning lessons bulletin published in March 2017.[14]

"Tragically, this reporting year has seen a sudden increase in the number of deaths of women in prison; this has risen to 23 in 2016–17."

[13] Ministry of Justice (2016) 'Safety in custody quarterly bulletin: December 2016', *Ministry of Justice Statistics Bulletin*. Online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/611187/safety-in-custody-statistics-q4-2016.pdf

[14] Prisons and Probation Ombudsman (2017) *Self-inflicted deaths among female prisoners*. London: PPO.

Ms J had a complex social anxiety disorder, a history of substance misuse and minor self-harm, and had spent time in prison before. She faced disciplinary hearings for fighting with other prisoners, being abusive and violent to staff and diverting her medication. After arguing with another prisoner about drugs, staff moved Ms J to another spur but she was bullied and taunted by other prisoners, who later alleged that she had sexually assaulted and harassed them.

A couple of months later, Ms J tied a dressing gown cord around her neck after someone stole from her. Staff monitored her under suicide and self-harm prevention procedures for several days but this stopped when they considered she appeared more positive. The next day, Ms J fought with another prisoner, and staff locked them both in their cells. Prisoners shouted abuse at Ms J at lunchtime and a short time later, she was found crying, with wool tied around her neck. Staff spoke to her for 10 minutes, and started monitoring her again under suicide and self-harm prevention procedures, with observations twice an hour. At the first two checks, staff were satisfied that Ms J was fine but on the third check they found Ms J unconscious on the cell floor with two ligatures around her neck. Ms J was taken to hospital but died two days later.

On the day of the fight, staff appropriately began monitoring Ms J and used their knowledge of her to set observations at twice an hour. With hindsight, we believe that Ms J's risk factors justified constant supervision, but this was not considered.

Overall, Ms J received some good care in prison. She was the victim of an orchestrated campaign of bullying by other prisoners, which was well investigated, with sanctions applied to the perpetrators and appropriate support given to Ms J by staff. There was evidence of good management of Ms J's complex needs, including her mental health and substance misuse.

However, Ms J's case illustrates the difficulties faced by staff in managing a wide range of challenging behaviours, in a setting with limited options for doing so. Ms J was housed in a detoxification unit for women with substance misuse issues. It was not clear where prisoners who were detoxifying, but who were also involved in bullying or being bullied or had other complex needs, could be located so that they could be adequately cared for. The way services were configured at the prison appeared to constrain the options available for staff to manage prisoners' needs effectively.

It was Ms K's first time in prison. She had tested positive for drugs and had a personality disorder. Ms K harmed herself in prison, and staff monitored her risk of suicide and self-harm several times. She was housed in a unit for women with complex needs but during the last month of her life, her emotional health and self-harm got worse and staff monitored her daily. Ms K was found guilty at disciplinary hearings and received punishments, preventing her from mixing with other prisoners.

A week before she died, Ms K tied a ligature around her neck and later told an education manager that no one was listening to her, she felt mistreated by staff and she was close to killing herself. At an ACCT case review, she seemed positive and reported no thoughts of suicide so staff decided that Ms K should return to a standard residential unit, and she hanged herself behind the houseblock. No one noticed she was missing for about two and a half hours, even though Ms K should have been locked in her cell and monitored every 30 minutes under ACCT procedures. When they found her, staff and paramedics were unable to save her life.

It was unacceptable that no one looked for Ms K all afternoon, particularly as staff were required to monitor her at half-hourly intervals. We were also troubled by Ms K's allegations of bullying by staff and felt that what should have been a supportive environment did not appear to have been so.

The decision to move Ms K to a residential unit was understandable, as she seemed positive and reported no thoughts of suicide at the case review on the day before she died. However, the mental health team leader did not agree with the move and while the chair of the ACCT review did not know this, it is possible that an enhanced case review approach might have surfaced these tensions. It might also have highlighted the impact of punishments from three disciplinary hearings on Ms K's health and welfare, which was at odds with the support and care she needed because of her risk of suicide and self-harm. There were serious, apparently systemic failings in the way staff operated ACCT procedures. In particular, staff failed to monitor Ms K effectively and to record their actions and observations.

Both these women had complex needs and displayed challenging behaviours, which were very difficult for staff to manage. Staff in Ms J's case spent around 10 minutes talking to her when she tied a first ligature around her neck on the day she died. While in the context of a busy prison, this is a significant amount of time, it is a short period in which to assess someone's risk properly and effectively. Ms K might have been better managed under the enhanced ACCT case management process, to ensure more senior staff and relevant specialists were involved in multidisciplinary case reviews.

“Ms K might have been better managed under the enhanced ACCT case management process, to ensure more senior staff and relevant specialists were involved in multidisciplinary case reviews.”

Deaths from natural causes

Deaths from natural causes continue to account for the majority of fatal incident investigations in prison. This is largely explained by the increase in older prisoners and associated age-related conditions.[15] Our natural cause investigations focus, in particular, on the need for prisons to provide appropriate healthcare at a level equivalent to that which could be expected in the community. We also examine whether security measures and broader prison management were proportionate to the risk posed by the individual, and whether dying prisoners and their families were treated with appropriate sensitivity and respect.

Healthcare

In many of our investigations, we found evidence that healthcare staff had treated prisoners who had died from natural causes, in a caring and compassionate manner, which was judged by our clinical reviewers to be equivalent to the treatment they could have expected to receive in the community.

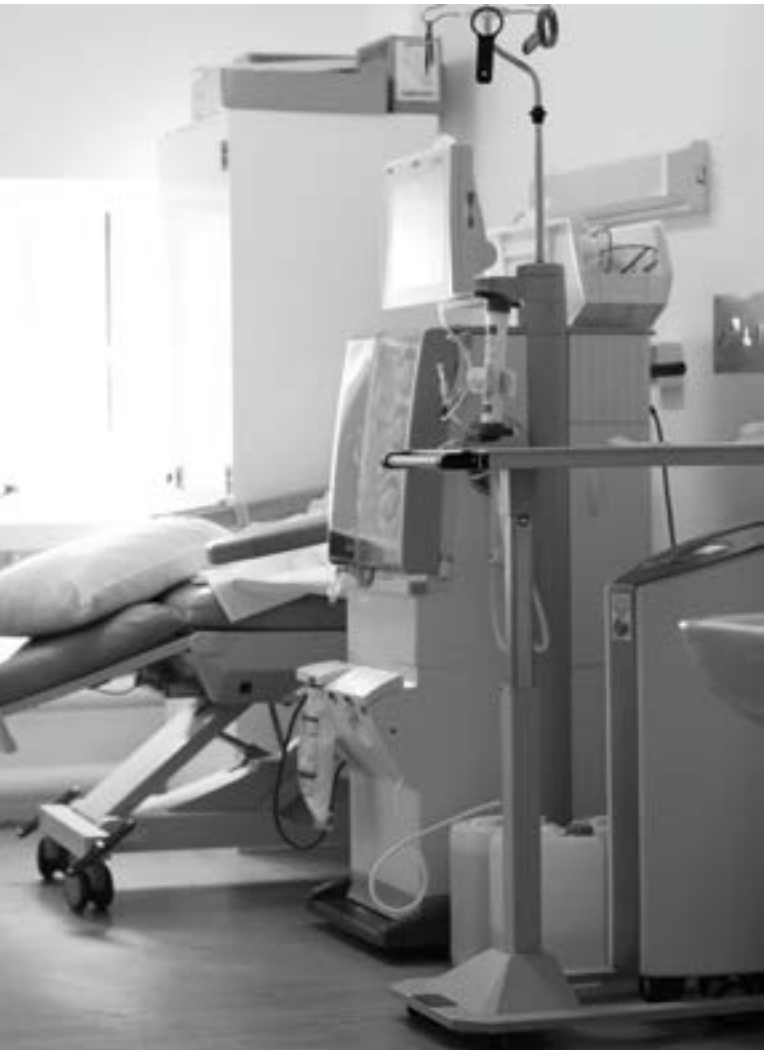
“In many of our investigations, we found evidence that healthcare staff had treated prisoners who had died from natural causes, in a caring and compassionate manner.”

However, this was not always the case. Too many investigations found instances of healthcare staff failing to make urgent referrals to specialists when they had concerns that a prisoner might have cancer. Delays can prevent early diagnosis, early treatment and even result in unnecessary deaths. Similar problems arose when healthcare staff failed to review and treat abnormal blood test results.

Our investigations also found instances where clinicians were unaware of, or failing to keep up to date with, National Institute for Health and Care Excellence (NICE) guidelines for managing chronic conditions, such as chronic obstructive pulmonary disease or heart disease. This can result in unnecessary exacerbation of the condition and increased pain for the patient.

In most healthcare settings, we saw evidence of staff using some form of early warning score to assess and respond to acute illnesses. However, not all staff seemed to know what certain scores meant and how they ought to respond, which sometimes led to prisoners remaining in prisons, acutely ill, rather than being admitted to hospital.

[15] Prisons and Probation Ombudsman (2017) *Older prisoners*. London: PPO.



It is important that prisoners receive effective continuity of care when they move into custody from the community, or from prison to hospital and back again, including good communication between healthcare professionals in both settings. On occasions, our investigations found examples of medical records, particularly community medical records and hospital discharge information, not being properly managed or shared and, as a consequence, prisoners did not receive appropriate treatment. Prisons also frequently failed to record the reasons for prisoners not attending planned appointments.

Mr L was sentenced to 24 years for sexual offences. After eight months in prison, Mr L began to show signs of confusion, disorientation and incontinence. He was sent to hospital where hospital doctors wanted to perform an MRI scan. However, the scan could not be done because the prison was unable to confirm that it would be safe, because they had not obtained Mr L's community medical records which hold the necessary information. Once the records had been obtained, the prison overlooked the second request for an MRI scan contained in a hospital discharge letter. When an MRI scan was finally performed, it revealed that Mr L had an inoperable brain tumour. He died five days later.

Shortly before arriving in prison, Mr M had been diagnosed with bladder cancer and his bladder had been removed. In order to check that his cancer had not spread, Mr M regularly went to hospital for various checks.

However, when Mr M moved prisons, his previous prison did not pass on information about his forthcoming hospital appointments. Mr M missed these hospital appointments and then began to suffer from urinary tract infections, partially caused by his bladder cancer. Mr M died from sepsis, caused by a urinary tract infection and bladder cancer.

Restraints

While prisons have a fundamental duty to protect the public, this has to be balanced by treating prisoners with humanity. The use of restraints needs to be based on the actual risk posed by the prisoner at the time and informed by the impact of any health condition on that risk.

The High Court holding, in the case of *Graham v the Secretary of State for Justice,*[16] that using handcuffs on Mr Graham while he received life saving-chemotherapy, infringed Article 3 of the European Convention of Human Rights' prohibition of inhuman and degrading treatment, has reached its 10-year anniversary in 2017, but we continue to see too many seriously ill and dying prisoners with mobility issues being restrained with handcuffs and chains in hospital. Too often prison staff are unaware of the High Court judgement or its requirements.

> "...we continue to see too many seriously ill and dying prisoners with mobility issues being restrained with handcuffs and chains in hospital."

Mr N was sentenced to five years for sexual offences. Before entering prison, Mr N had been diagnosed with bowel cancer and hospital specialists wanted to treat this with chemotherapy.

Prison security staff constantly assessed that Mr N presented a low level of risk to the public and of escape. However, a prison manager instructed officers to restrain Mr N with double handcuffs during journeys to and from the hospital and with an escort chain (a long chain with a handcuff at each end) during his chemotherapy treatment. Over time, prison managers reviewed the appropriateness of using restraints and, seven months after his treatment began, decided to remove restraints altogether. Mr N died in a hospice later that month.

Double handcuffing means that the prisoner's hands are handcuffed in front of them and one wrist is then attached to a prison officer by an additional set of handcuffs. This is usually required for moving category A or category B prisoners in good health, yet Mr N was a category C prisoner in poor health. Had there been exceptional circumstances to justify this decision, the reasons should have been recorded but none were.

[16] *R (on the application of Graham) v Secretary of State for Justice* [2007] All ER (D) 383 (Nov).

We also frequently found that prisons were restraining prisoners on the basis of their offending history, in particular their index offence, as well as their historic risk. Medical advice about the extent to which a prisoner's health had deteriorated and the impact of that deterioration on the prisoner's actual risk to the public or of escape, was often not followed.

Emergency response

When a prisoner is found unresponsive, a quick and effective emergency response is critical. Unfortunately, while some emergency responses can be impeccable, with quick and determined attempts at resuscitation, others can leave much to be desired. For example, we found cases where staff failed to use appropriate emergency codes, control room operators did not immediately call for an ambulance or healthcare staff responded with unsuitable or broken emergency equipment. Inevitably, such failings reduce the likelihood that a prisoner will be successfully resuscitated.

"...we found cases where staff failed to use appropriate emergency codes, control room operators did not immediately call for an ambulance or healthcare staff responded with unsuitable or broken emergency equipment."

Shortly after arriving in prison, Mr O moved to the prison's inpatient unit because he was suffering from a disc protrusion. The next month, a healthcare assistant found Mr O unresponsive and shouted to another healthcare assistant for help. They pressed the alarm button to indicate that there was a problem rather than using a radio to call the appropriate emergency code. This meant that the right emergency equipment was not immediately taken to Mr O's cell and the call for an emergency ambulance was delayed. Despite resuscitation attempts by prison healthcare staff and paramedics, Mr O died that morning.

Investigations have also found instances of prison staff missing opportunities to check that a prisoner is alive and well – as they are required to do – during roll or welfare checks. These simple measures would increase the chances of prisoners receiving quick, emergency, and potentially life-saving, medical treatment.

Awareness and training is also important to enable staff to respond effectively to all aspects of emergencies. For example, our investigations have found instances of well-meant but ultimately futile attempts to resuscitate prisoners who have died and where death is apparent, in particular through the presence of rigor mortis – the stiffening of the body after death. We welcome the joint guidance on resuscitation, issued in September 2016 by the Prison and Probation Service, the Royal College of Nursing and the Royal College of General Practitioners[17] and hope to see fewer inappropriate instances of attempted resuscitation which are distressing for the staff involved and undignified for the deceased.

[17] National Offender Management Service, Royal College of Nursing and Royal College of General Practitioners (2016) *Guidance to support the decision making process of when not to perform cardiopulmonary resuscitation in prisons and immigration removal centres (IRC).* Available online at: https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/forums/nursing-in-justice-and-forensic-healthcare-forum/guidance-on-when-not-to-perform-cpr.pdf

Approved premises

Approved premises (previously known as probation hostels) hold offenders who require additional support and supervision in the community following their release from prison. Research indicates that offenders can be at heightened risk of death following their release into the community.[18] They are more able to indulge in risky behaviours and probation staff need to identify, monitor and address risk factors and apply learning from our investigations.

Mr P was required to reside at approved premises. He had a long history of drug and alcohol abuse and mental ill-health. He told staff at the approved premises that he was hearing voices and was afraid that he would hurt himself or someone else. After testing positive for cocaine opiates and alcohol he was reviewed by mental health practitioners where he disclosed that he had used 'spice' (NPS) while in prison. He was later found to be unsteady on his feet at the approved premises where staff suspected that he had taken NPS, which he denied. He tested positive for alcohol but provided a negative test for drugs. Three days later he was found dead from a drugs overdose in a nearby caravan.

Although the post-mortem found that Mr P died from fatal opiate poisoning, the inability of the approved premises' staff to test for NPS meant that they did not have a full picture of his risk on which to base their management decisions. Given the problems of NPS in the custodial setting and the risk of these problems affecting those under supervision in the community, we made a national recommendation that the National Probation Service should review its approach to drug testing in approved premises.

> "...we made a national recommendation that the National Probation Service should review its approach to drug testing in approved premises."

[18] Phillips, J., Gelsthorpe, L., Padfield, N. and Buckingham, S. (2016) *Non-natural deaths following prison and police custody*, research report 106. London: Equality & Human Rights Commission. Available online at: https://www.equalityhumanrights.com/sites/default/files/non-natural_deaths_following_prison_and_police_custody_2.pdf.

Mr Q was released on licence from a secure psychiatric unit to approved premises. He had a history of drug problems, and agreed to have drug tests, although he was not tested while at the premises.

He had a curfew between 9pm and 7am and three days later, Mr Q returned late to the premises, at 10pm. No staff at the premises questioned him or reported the incident to managers or to Mr Q's probation officer.

During morning checks, at 7.30am the next day, from outside his room staff heard Mr Q snoring so did not visually check on him. At 10.50am, two other members of staff carried out wellbeing checks and found Mr Q white and unresponsive. An ambulance was called immediately, but it was clear Mr Q had already died.

We were concerned that there had been no drug testing within the five days Mr Q was at the premises. When he returned outside of his curfew, we were troubled that staff did not appropriately report or escalate this, as they should have done, and that the welfare checks in the early morning were not completed appropriately.

Immigration removal centres

As in 2015–16, we investigated the deaths of three people in immigration removal centres (IRCs). Deaths in IRCs remain relatively rare. Detainees in IRCs are subject to a range of risk factors which are similar to those experienced by prisoners, some of which are magnified by the specific nature of their immigration status and the basis of their detention.

> “Detainees in IRCs are subject to a range of risk factors which are similar to those experienced by prisoners, some of which are magnified by the specific nature of their immigration status and the basis of their detention.”

Mr R was a foreign national who had a long history of mental health issues and had been moved between prisons and mental health units. After he was told that he would be deported, he frequently expressed suicidal thoughts and had tried to take his life.

When Mr R arrived at the immigration removal centre, he was taken to the enhanced care unit where he was constantly supervised under suicide and self-harm prevention procedures. Mr R received a prompt mental health assessment and his care plan specified that his medication should be strictly supervised. He repeatedly threatened to kill himself by taking an overdose of his medication. After an officer saw him taking a handful of tablets, Mr R was taken to hospital.

After some tests, the hospital discharged Mr R without clear care instructions. Mr R was sick three times between leaving the hospital and returning to his room in the immigration removal centre. He went straight to sleep. Staff found him unresponsive later that night and were unable to resuscitate him.

Despite some good mental health planning, overall, Mr R received inadequate medical care. Mr R’s death raised concerns about the supervision and administration of medication. After Mr R’s release from hospital, following an apparent overdose, there was no care management plan and no direct clinical oversight. If detention staff had adequately and safely monitored his physical health after his return from hospital, it might have changed the outcome for Mr R. There were several weaknesses in suicide and self-harm prevention procedures, most notably the lack of input from healthcare staff.

Investigating complaints

We received 5% more complaints in 2016–17 than in the previous year and 9% more eligible complaints. As in previous years, the majority of complaints were from adult male prisoners. They continued to cover a huge variety of subjects, ranging from relatively minor matters to serious allegations of misbehaviour by staff.

We upheld 38% of the complaints we investigated. This is a surprisingly high percentage considering all complaints have been through two internal stages before they reach us.

This year in particular, the pressures prisons are under have been reflected in an increasing failure by some prisons to get the basics right. For example, we have seen more cases where staff failed to record what they had done and why. This has always been an issue in complaints about how prisoners' property is handled, but this year we have upheld more complaints about other matters, such as decisions about prisoners' privilege levels,[19] simply because there was no evidence to show that required procedures had been followed or to explain and justify why a decision had been made.

> "...there was no evidence to show that required procedures had been followed or to explain and justify why a decision had been made."

We have also experienced more difficulty obtaining the information that is needed to investigate a complaint. It has become much more common for us to have to chase repeatedly for information and in some cases prisons have failed to respond at all.

Complaint handling

The pressures on prisons have been reflected particularly clearly in the way they are handling internal complaints. As mentioned in the introduction, many complaints that reach our office have done so because prisons have failed to manage their internal complaints process effectively. This has meant that we have investigated more cases than last year about complaint handling, and in addition we have seen evidence of a poorly functioning complaints process when investigating complaints about other subjects.

[19] See section on incentives and earned privileges (IEP p56).

All of this matters. Prisoners need to have confidence that their complaints will be considered objectively and promptly and that legitimate concerns will be addressed. Prisons need to record complaints and their outcomes accurately as a driver for improvement. It is a cause for real concern that too many prisons are not getting this right.

The case of Mr A, for example, brought to light a disturbing catalogue of shortcomings. Many of the responses he received from prison staff did not address his complaints: some said they could not provide an answer and that he should approach someone else in the prison; some ignored the point of the complaint and provided irrelevant information; some simply dismissed his complaints without explaining why.

One of his appeals was returned to him unanswered because he had submitted it on an adapted first-stage complaint form as there were no appeal forms available on his wing. On three occasions he was told that his complaints had not been upheld, even though the person responding had explicitly accepted that he had valid grounds for complaint.

A complaint about the shortage of work placements was returned to him unanswered because he had not sought to resolve the complaint informally first, even though there is absolutely no requirement for prisoners to do this before submitting a complaint (and it is doubtful in any case whether a complaint of this nature could have been resolved informally). A complaint about not receiving a copy of his parole dossier was returned unanswered on the grounds that it either covered multiple subjects (which was incorrect), or that he had submitted an excessive number of complaints (which was also incorrect) – the prison could not tell us which. When he tried to submit a second complaint on the same subject it was returned marked 'duplicate' (even though his original complaint had not been answered), so his complaint about his parole dossier was never addressed.

We upheld Mr A's complaint about the handling of his complaints and made a number of recommendations.

Although this was one of the worst examples of complaint-handling we saw, the same problems were occurring in many other cases.

> "We saw an increase in straightforward complaints that should have been resolved locally, but where no one seems to have made any effort to do so."

We saw an increase in straightforward complaints that should have been resolved locally, but where no one seems to have made any effort to do so. Typical examples involve unpaid wages of relatively small amounts of money or purchases that were never delivered. Now that the internal complaints process only consists of two stages, it seems all too easy for busy junior staff to tell prisoners to complain to the Ombudsman rather than trying to sort these problems out themselves.

> “…it seems all too easy for busy junior staff to tell prisoners to complain to the Ombudsman rather than trying to sort these problems out themselves.”

We also saw too many cases where it took several weeks or even months for prisoners to receive responses to routine complaints; where the same person replied at both stages of the complaint; and where prisoners received replies from the person they had complained about.

A case that raised another important issue was that of Mr B.

Mr B complained that he was unable to take his complaint about his medical treatment outside the prison. He was a prisoner at a private prison in Wales where healthcare is provided by a private sub-contractor and not by the NHS. We found that complaints about medical treatment provided by this sub-contractor would be answered by the sub-contractor in the first instance.

If prisoners are not satisfied with the response they receive, there is no external body that they can appeal to. This is clearly not acceptable. What is needed is an independent body that has the medical expertise to consider complaints and the authority to bring about change and facilitate a remedy where necessary.

We recommended that a clearly sign-posted complaints procedure for healthcare complaints should be put in place at the prison by the end of March 2017 (later extended, by agreement, to the end of May 2017). Our recommendation was accepted.

Property

Complaints about lost and damaged property continued to be the largest category of complaints (amounting to 29% of all the complaints we investigated). As in previous years, we upheld a high percentage of these complaints (57% against an overall uphold rate of 38%).

As previous annual reports have said, people in custody often attach a lot of importance to their personal possessions as a way of maintaining a sense of identity and some freedom of choice. This is, therefore, an area where we can make a real difference for individuals.

> “…people in custody often attach a lot of importance to their personal possessions as a way of maintaining a sense of identity and some freedom of choice.”

However, property complaints can be time-consuming to investigate and use resources that could be better spent on more serious complaints. Prisons are also using scarce resources paying compensation for lost and damaged property.[20]

It is, therefore, depressing to have to record, yet again, that most of the complaints we upheld need never have arisen if establishments followed national policy on the handling and recording of prisoners’ property. In addition, most of these complaints could and should have been resolved by establishments without prisoners needing to approach us.

[20] We made 72 recommendations for compensation to be paid for lost and damaged property. In addition, prisoners will have been awarded compensation through the courts, and prisons will have agreed to pay compensation in private settlements. It is worth making the point that, although compensation is better than nothing, most prisoners would much prefer to have their property returned to them.

We have written to the prisons with the worst uphold rates for property complaints, drawing their attention to the steps they can take to improve (set out in our learning lessons bulletin).[21] However, it is really time for the Prison and Probation Service, as a whole, to get a grip on the way prisoners' property is managed. The method of recording property needs to be brought into the twenty-first century; staff need time to follow the proper procedures; and prisoners' property needs to travel with them when they transfer between establishments (instead of following on weeks or months later). If these basic issues were tackled it would reduce a significant source of frustration for prisoners and an unnecessary waste of resources in establishments and this office.

> "...it is really time for the Prison and Probation Service, as a whole, to get a grip on the way prisoners' property is managed."

A typical example is the case of Mr C who complained that a suit, shirt and tie (which had been held in his stored property) did not arrive at his new prison when he was transferred. Six months after his transfer, his previous prison finally replied to his complaint. They apologised for any inconvenience caused and told him that they would send his property on to him as a matter of urgency. Nearly two months after that, they told him that their records showed that the property had in fact been transferred with him and was, therefore, at his new prison after all. Our investigation found that this was not correct and that the bag with the missing property had never left the original prison. As the bag could not be located, we recommended that Mr C receive compensation for the missing property (after making a deduction for wear and tear as there was no evidence that the lost items were brand new).

[21] Prisons and Probation Ombudsman (2014) *Learning lessons from PPO investigations: Prisoners' property complaints*. London: PPO.

Most of the complaints we see about property were genuine, but, of course, this is not always the case.

Mr D, for example, complained that most of his clothes went missing when he was transferred from one prison to another. Our investigation found that the cell clearance procedures had not been completed when Mr D left his previous prison. We also found that, far from losing property when he transferred, Mr D had in fact arrived at his new prison with significantly more property than he should have had in his possession – 10 pairs of trainers rather than the four shown on his property cards, for example, and an extra DVD player and stereo – and had since handed some of these items out to his family on visits. The most likely explanation was that he had obtained these extra items from other prisoners by theft or bullying. If the cell clearance procedures had been completed at his previous prison these unauthorised items would have been identified and removed from him. As it was, they had simply been packed up and sent on, and Mr D had taken advantage of the lack of paperwork to avoid detection and to submit a false claim.

Adjudications

Adjudications are another perennial source of complaints. In these cases, our role is not to rehear the evidence, but to satisfy ourselves that the adjudicator followed the proper procedures, made sufficient inquiry into the prisoner's defence to ensure a fair hearing, and imposed a proportionate punishment. We upheld only 18% of complaints about adjudications, which indicates that prisons are getting this right for the most part, although there are always exceptions.

“We upheld only 18% of complaints about adjudications, which indicates that prisons are getting this right for the most part, although there are always exceptions.”

Where a prisoner is found guilty of damaging prison property at an adjudication, he or she can be required to pay compensation, and we receive complaints about this. The Prison Service Instruction[22] makes it clear that there is no punitive element to the compensation order, it is simply an amount to cover the full cost of the damage up to a maximum of £2000. The debt is written off after two years or when the prisoner is released (whichever is sooner). The instruction also says that prisoners should be left with a minimum spending power of £5 a week after paying the compensation, and that governors must take the prisoner's individual circumstances into account when deciding how much he or she should be left with.

Mr E complained that the compensation he was required to pay was excessive and had left him without enough money to buy food, toiletries and clothes or to telephone his family. He said this was causing him significant hardship and was affecting his mental and physical health.

Our investigation found that Mr E had been ordered to pay compensation on four occasions, at two separate prisons, over a period of about a year. On three occasions the compensation had been set at, or just below, the maximum of £2000, after he had caused extensive damage to his cell. On the fourth occasion, the compensation had been set at £34 for damaging some of the contents of his cell. We also found that Mr E had been left with £5 spending money a week at his two previous prisons (where the damage had been caused) but that this had been raised to £7.50 at his current prison.

We were satisfied that the compensation levels were appropriate. We were also satisfied that £7.50 a week spending money was a fair figure given Mr E's needs and the need to make meaningful inroads into the compensation he owed.

[22] PSI 31/2013 (Recovery of monies for damage to prisons and prison property).

We noted that it gave him greater spending power than other prisoners who were unemployed through no fault of their own, and only 50p a week less than some prisoners who worked full time. We did not, therefore, consider that Mr E's hardships were any worse than those faced by many others in prison.

We were, however, concerned that there was no evidence that any consideration had been given to Mr E's personal circumstances in setting his minimum weekly spend. It seemed likely that his two previous prisons had routinely imposed the £5 minimum level. We recommended that the governors of those prisons should review the spending power of every prisoner paying compensation on a case by case basis, as required by the Prison Service Instruction.

Incentives and earned privileges (IEP)

The IEP scheme enables prisoners to earn additional privileges as a result of good behaviour. Its aim is to incentivise prisoners to behave well and work towards their rehabilitation. A prisoner's IEP status can make a significant difference to his or her quality of life. A prisoner on the 'basic' level, for example, will typically be required to wear prison-issue clothing,[23] will receive only the minimum entitlements in terms of visits, phone calls, exercise and out of cell activity, and will not be allowed a television or anything other than basic possessions in their cell. Prisoners on the 'standard' and 'enhanced' levels will be allowed more possessions and will be allowed more time out of cell and in the gym and more opportunities for contact with family and friends. It is not, therefore, surprising that we regularly receive complaints about IEP levels.

National policy requires staff to follow certain basic procedures for downgrading and reviewing prisoners' IEP levels to ensure that these important decisions are made in a fair, objective and transparent way.[24] We see a number of cases where these procedures have not been followed.

[23] Not for prisoners in the female estate.

[24] Set out in PSI 30/2013 (Incentives and earned privileges).

An example was the case of Mr F, who complained that he had been on 'basic' for three months without a review. National policy says that when a prisoner is on 'basic', this must be reviewed after seven days and at least every 28 days after that. There should be no minimum 'term' to be served and a prisoner should be restored to 'standard' level once he has demonstrated compliance with the behavioural targets set for him.

We found that Mr F's prison had a local 'zero tolerance' policy under which any prisoner found in possession of a weapon, or strongly suspected of involvement in the weapons culture, would be automatically downgraded to 'basic' for a minimum period of three months. The prison told us that Mr F's status 'would have been' reviewed regularly in line with national policy. However, we found that the local policy did not include any provision for a review until after three months. In addition, the prison could not provide any evidence that Mr F's status had been reviewed or that he had been set any behavioural targets. This was at odds with the national policy and meant that, however well Mr F behaved, there was nothing he could do to improve his IEP level. We recommended that the local policy be amended to bring it into line with national policy and that the prison review the status of all prisoners currently subject to the local policy.

This case also illustrates the problems that can arise when prisons develop local policies. We have seen a number of cases this year of local policies that lack basic safeguards and checks, or that are so poorly drafted that they are ambiguous, contradictory or simply unintelligible. This issue may become more acute if authority is increasingly devolved to governors under prison reforms, which is why the Ombudsman has called for a national code of prison minimum standards.

"This issue may become more acute if authority is increasingly devolved to governors under prison reforms, which is why the Ombudsman has called for a national code of prison minimum standards."

Contact with family and friends

Maintaining family ties helps prisoners settle successfully in the community on release and can therefore help to prevent reoffending.[25] Maintaining family contact while in prison also reduces isolation and the pain of imprisonment for both prisoners and families. However, prison staff have to balance the potential benefits of maintaining family ties against their fundamental responsibility for ensuring security and public safety. This balance is not always easy to achieve, nor do staff always get this right.

> “
>
> …prison staff have to balance the potential benefits of maintaining family ties against their fundamental responsibility for ensuring security and public safety.”

Governors are naturally concerned about and want to take action to prevent contraband (especially drugs and mobile phones) entering prisons. This has led some prisons and young offender institutions to develop local policies that are overly restrictive and not in line with national policy, and we have dealt with a number of complaints about such local policies this year.

There will be occasions when stringent restrictions to contact with friends and family will be entirely appropriate (see the case of R below, for instance) but such restrictions must be justified and proportionate. For example, requiring all visits to take place under closed (no contact) conditions would undoubtedly help to prevent the flow of contraband, but to do so would be wholly disproportionate. The relevant Prison Service Instruction[26] makes it clear that closed visits should be applied only where prisoners are proved or reasonably suspected of smuggling items through visits. The instructions also say that closed visits must be reviewed on a monthly basis to decide whether there is still a need for them.

[25] Department of Business Innovation and Skills and National Offender Management Service (2014) *‘Parenting and relationship support programmes for offenders and their families’: Volume One: A review of the landscape.* Accessed online: https://policis.com/pdf/moj/MOJ_BIS_Parenting_support_for_offenders_and_families_Volume_1_28014_FINAL.pdf

[26] PSI 15/2011 (Management of security at visits).

Mr G (who was 20 at the time) complained that he was placed on closed visits after a mandatory drugs test (MDT) proved positive. We found that the young offender institution where Mr G was held had a local 'zero tolerance' policy on drugs, where any prisoner who failed a MDT would automatically be placed on closed visits for three months. In addition, a further failed MDT would automatically result in the three months of closed visits being restarted.

Our investigation showed that Mr G had had no visits during the four months before he failed the MDT. This meant that it was extremely unlikely that he obtained the drugs he was using through a visit, and there was no intelligence or any other evidence that Mr G was bringing any items in through visits. It was therefore clear, that closed visits had been imposed automatically, simply because he had been caught using drugs. This was contrary to the Prison Service Instruction.

We also found that, although the prison conducted monthly reviews in line with the instruction, these were essentially meaningless: Mr G was kept on closed visits for three months purely on the basis that local policy said he should be. There was no new intelligence and nothing Mr G could have done to shorten the term. We upheld Mr G's complaint and recommended, among other things, that the governor revise the local policy and review all current closed visits cases to ensure that decisions had been made in line with national policy.

We have found similarly flawed local 'zero tolerance' policies in a number of adult establishments as well.

Legally privileged mail

Some prisons have also introduced inappropriate local policies on the handling of legally privileged mail (known as Rule 39 mail), requiring prisoners to hand outgoing Rule 39 post to staff unsealed. As we said in last year's annual report, the relevant Prison Service Instruction[27] makes it quite clear that legal correspondence should be handed in, already sealed, and should not be opened by staff, other than in exceptional circumstances, where there is a good and specific reason – and even then, it should be opened in the presence of the prisoner. It is, therefore, disappointing that that this very well-established rule is still being breached at some prisons.

As in previous years, we received a steady stream of complaints about incoming Rule 39 mail being opened by staff in contravention of Prison and Probation Service policy. It remained the case, however, that we did not find evidence to suggest that this was being done deliberately – although we obviously remain alive to this possibility. Instead, it appeared to be down to poor staff training and poor management.

Apart from securing an apology, there is not much we can achieve for the prisoner in one-off cases. In the case of Mr H however, we went further.

[27] PSI 49/2011 (Prisoner communication services).

Mr H complained that his Rule 39 mail had been opened repeatedly. Our investigation found that Mr H's legal mail had indeed been opened on a number of occasions. Mr H suggested this was the result of a targeted campaign prompted by (unrelated) legal action he was taking against the Prison and Probation Service. We took this allegation very seriously but we could find no evidence to suggest that Mr H's mail was being opened deliberately. We did, however, find evidence of poor training and inadequate procedures in the prison's mail room. We also found that, despite repeatedly assuring Mr H that action was being taken, the prison had failed to address the issue over a period of several months.

This made it one of the worst cases of its kind that we have seen. Although the Ombudsman does not normally recommend financial redress in cases where there has been no financial loss, we considered that in this case it would be appropriate for the prison to make a small ex gratia payment (£50) to Mr H in recognition of their extremely poor performance in this case. We also recommended that the prison carry out a full review of the mail room's processes and staff training.

Employment

Employment is another important issue for many prisoners. It provides them with money to make telephone calls to their families, to rent a television, and to pay for extras such as tobacco, food and clothes. Without this money, prisoners can easily get into debt and experience pressure from other prisoners to get involved in antisocial activities. Employment can also play a key role in equipping prisoners for life in the community after release.[28]

The loss of employment is, therefore, a serious penalty for a prisoner and, as we said in our learning lessons bulletin on the subject,[29] prisons need to follow fair employment practices. Although immediate dismissal will be justified where there has been serious misbehaviour or breaches of trust, in most cases prisoners should receive a warning and have the opportunity to improve before they are dismissed. Unfortunately, we have continued to see too many cases where this has not happened.

We have also received complaints from prisoners who want to work but are unable to do so.

[28] Hunter, G. and Boyce, I. (2009),'*Preparing for employment: prisoners' experience of participating in a prison training programme*', The Howard Journal Vol 48, No 2. May 2009, pp. 117–131. See also Ministry of Justice (2016) '*Justice Data Lab analysis: Re-offending behaviour after participation in the Clink Restaurant training programme*'. Accessed online: http://socialwelfare.bl.uk/subject-areas/services-client-groups/adult-offenders/ministryofjustice/179441clink-report-final.pdf

[29] Prisons and Probation Ombudsman (2013) *Prisoner dismissal from employment*. London: PPO.

> “Employment can also play a key role in equipping prisoners for life in the community after release.”

Mr I complained that he had been unemployed for more than four months. He said that he was spending an average of 19.5 hours a day in his cell and that this was disturbing his sleep pattern and causing him to become anxious and depressed.

We found that when Mr I first arrived at the prison, he had been fully employed for three months until he was dismissed for an alleged (minor) breach of trust. After that, despite applying for several suitable jobs, he had been unemployed for some months, although he had done some part-time education courses for short periods.

The prison told us that their population had expanded a year earlier and, as a result, about 25% of prisoners were currently unemployed at any one time. They said that new workshops had just been built and work was ongoing to recruit more staff to allow prisoners to have more time out of their cells.

We did not doubt that managers were doing what they could in difficult circumstances, but we considered the lack of full-time purposeful activity for so many prisoners unacceptable. We upheld Mr I’s complaint and recommended that the Prison and Probation Service work closely with the governor to identify ways of attracting and retaining the necessary staff to enable a full programme of activity to be made available.

Categorisation

Security categorisation was a frequent subject of complaints. This is not surprising since a prisoner's security category can have a significant impact on their ability to progress towards release.

As in previous years, most of the complaints we received were about being refused category D status (and therefore not being considered suitable for an open prison) or about being re-categorised from D to C (and therefore being returned from an open prison back to a closed prison). Whatever the circumstances, Prison and Probation Service policy[30] requires that prisoners are held in the lowest appropriate security category and that any decisions made are transparent and based on evidence.

It is not our role to decide what a prisoner's category should be. Risk assessment and risk management are quite properly the responsibility of those who deal with prisoners on a day-to-day basis. However, it is appropriate for us to consider whether national policy has been followed and whether relevant factors have been taken into account. The following, slightly unusual cases, illustrate this.

Mr J complained that he had been wrongly categorised as category B when he transferred from the juvenile to the adult estate at the age of 21. We found that the original categorisation decision was perfunctory – we could see no evidence that the decision-maker had considered the offending behaviour work Mr J had already undertaken, or that anything had been taken into account other than Mr J's sentence length.

We concluded that this was largely due to the fact that there was no clear guidance on what must be considered when a prisoner transfers to the adult estate in order to determine their category. We recommended that HM Prison and Probation Service amend the relevant Prison Service Instruction accordingly.

(The prison had already reviewed Mr J's categorisation and recategorised him as C.)

Mr K complained that he had not been granted an oral hearing for his category A review. Prison Service Instruction 08/2013 emphasises that those making decisions must be alive to the advantages of an oral hearing, both in aiding decision making, and in recognising the importance of the issues to the prisoner.

[30] PSI 40/2011 (Categorisation and re-categorisation of adult male prisoners).

The instruction sets out which factors might tend towards an oral hearing and we considered that all the relevant factors were present in Mr K's case – Mr K had been a category A prisoner for over 20 years and was 13 years post-tariff and had never previously had an oral hearing. There could, therefore, be little doubt of the importance of this issue to him; in addition, we were not satisfied that it had been made clear to Mr K what he needed to do to secure progression, or that he felt his views had had a fair hearing; and we were not satisfied that the reason his request for an oral hearing had been refused had been adequately explained to him.

We therefore recommended that the Prison and Probation Service should review its decision not to conduct an oral hearing. We also recommended that the Prison and Probation Service should provide Mr K with a more detailed explanation of its decision if it concluded that an oral hearing would not be appropriate. (This would enable him to mount a meaningful legal challenge if he wished.)

Segregation

Segregation, especially for prolonged periods, can be mentally and emotionally damaging.[31] For these reasons, national prison policy[32] says that segregation should be for the shortest period of time consistent with the original reasons for separation; that reviews must consider the prisoner's ability to cope in segregation; and that any prisoner segregated for more than 30 days must have a care plan setting out how their mental health will be safeguarded. This does not always happen, as the case of Mr L illustrates.

"Segregation, especially for prolonged periods, can be mentally and emotionally damaging."

[31] Shalev, S. and Edgar, K. (2015) '*Deep Custody: Segregation Units and Close Supervision Centres in England and Wales*'. Kent: Prison Reform Trust, Accessed online: http://www.prisonreformtrust.org.uk/Portals/0/Documents/deep_custody_111215.pdf

[32] PSO 1700 (Segregation, Special Accommodation and Body Belts).

Mr L complained about the length of time he had been segregated at a high security prison. Our investigation found that he was segregated for reasons of good order and discipline under Prison Rule 45, on the basis of security intelligence that he posed a risk to other prisoners. We reviewed the intelligence and we were satisfied that it had been properly evaluated and that the initial decision to segregate Mr L had been reasonable in the circumstances. Mr L was told from the beginning that he was being segregated pending a transfer to another high security prison and we also considered that this was reasonable in the circumstances.

However, we were concerned that Mr L remained in segregation for an excessively long time – four months – before returning to a normal location at the same prison. Although formal reviews were carried out regularly, we were not satisfied that these amounted to meaningful consideration of whether continuing segregation was necessary. We were also concerned that the segregation regime was very poor, that Mr L did not have a care plan and that there was no evidence that any steps were taken to safeguard his psychological health. We made recommendations on all these points.

Equality and diversity

We continue to be concerned about the inadequate way in which complaints about discrimination are too often treated by prisons.

A typical example is that of Mr M who appealed against being given an IEP warning for locking up late. He said that this was his first warning in three years and was not warranted as he had not been late in locking up and had not affected the regime in any way.

He said another minority ethnic prisoner had received a warning at the same time for the same reason, but at least 20 other prisoners who were still on association when he locked up, had not. Mr M also said that the officer who had issued the warnings had a history of discriminating against minority ethnic prisoners and that he had previously expressed concerns about the officer to managers. He asked for his complaint to be investigated by the prison's equalities team.

At various stages Mr M received responses from a senior officer, a wing manager and a senior manager. They said they could find no evidence of racial prejudice and that the officer had simply been following wing rules. Mr M was also told that his complaint had been passed to the equalities team, who 'would investigate in time'. After Mr M chased for a reply, the prison's (part-time) equalities officer wrote to him and apologised for the delay saying that they only had limited time to spend on the equalities role.

When he heard nothing further, Mr M wrote to the Ombudsman six months after he had originally complained.

Prison Service Instruction 32/2011 makes it clear that responsibility for ensuring equal treatment lies across the establishment and that it is therefore appropriate for generalist staff to investigate complaints about racism. We have no issue with that as a principle. However, in this case Mr M had been told that the equalities team would investigate his complaint – and they did not do so.

Moreover, we saw nothing to suggest that Mr M's complaint about unequal treatment had been considered or investigated by anyone else. Those who responded to his complaint relied wholly on the wing rule. However, the wing rule simply says that a warning 'may' be given. There is, therefore, discretion and those responding to Mr M's complaint should have considered whether that discretion had been appropriately applied. We saw no evidence that this had happened. No attempt was made to investigate the particular circumstances described by Mr M or to consider whether a simple word with him might have sufficed in those circumstances (rather than a warning). We, therefore, concluded that we could not be satisfied that the warning was appropriate. We also concluded that the prison's investigation into Mr M's complaint of discrimination had been inadequate.

There have always been complaints about discrimination on the grounds of race and religion, but this year we investigated an increased number of complaints from transgender prisoners as well.

"There have always been complaints about discrimination on the grounds of race and religion, but this year we investigated an increased number of complaints from transgender prisoners as well."

Ms N, a transgender woman in a male prison, complained about being employed in work she considered inappropriate, about being made to wear male prison-issue clothing at work, and about being sexually harassed by other prisoners in the workshop (who she said made inappropriate sexual comments and watched through the window when she used the toilet).

Our investigation found no reasons why Ms N's job was inappropriate. We also found that the work clothes she was required to wear were standard protective trousers (which had been altered to make them more feminine) and unisex trainers. She was able to wear female clothes when she was not at work. We were satisfied that this was in line with Prison Service Instruction 07/2011 (which says that transgender female prisoners should be allowed to wear female clothing, with the only exception being for 'relevant work clothes'). We did not uphold these elements of Ms N's complaint.

However, we were concerned that, although a senior manager told Ms N that her complaint of sexual harassment would be investigated, this had not happened. We, therefore, upheld this part of her complaint and recommended that an investigation take place.

Prisoner on prisoner violence

With rising levels of violence in prisons,[33] it is not surprising that we continued to receive complaints from prisoners who had been assaulted by other prisoners. In such cases, we look to see whether there was anything staff could have done to prevent the assault and/or to support the prisoner after the attack.

[33] Ministry of Justice (2016) 'Safety in custody quarterly bulletin: December 2016', *Ministry of Justice Statistics Bulletin*. Online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/611187/safety-in-custody-statistics-q4-2016.pdf

For example, Mr O complained about being attacked by another prisoner in the exercise yard. Our investigation found that staff had received fairly detailed intelligence that a named prisoner was being made to assault another prisoner in the exercise yard that afternoon, in order to pay off a debt. They found out that the potential victim was gay and was to be 'punished' for kissing his boyfriend during visits. From the intelligence, staff were able to identify Mr O as the potential victim from the description given and they stopped the perpetrator from exercising that day.

No further intelligence was received to say that Mr O was still at risk, but two days later he was attacked in the exercise yard by another prisoner. We considered that the prison should have taken steps to support and protect Mr O once he was identified as a potential victim and we recommended that the governor apologise to him.

Staff behaviour

Although complaints about staff behaviour made up 8% of our caseload, complaints about alleged physical abuse by staff were thankfully low. We investigated 39 such allegations in 2016–17, compared with 44 the year before. They are, however, among the most serious complaints that we receive.

"Although complaints about staff behaviour made up 8% of our caseload, complaints about alleged physical abuse by staff were thankfully low."

Prisons can be violent places. The use of force must, therefore, always be available to staff as an option. It is crucial, however, that staff use force only when strictly necessary and that any force used is proportionate to the circumstances.[34] Our investigations help to ensure that staff are held accountable for any misbehaviour, and they can be equally important in providing reassurance that the use of force by staff was necessary in other cases, for the preservation of security and safety.

[34] National prison policy on the use of force is set out in PSO 1600. This says that the use of force is justified, and therefore lawful, only if it is reasonable in the circumstances; necessary; if no more force than is necessary is used; and if it is proportionate to the seriousness of the circumstances.

> “Prisons can be violent places. The use of force must, therefore, always be available to staff as an option. It is crucial, however, that staff use force only when strictly necessary and that any force used is proportionate to the circumstances.”

A case that caused us some concern was that of Mr P, who complained that he had been assaulted by staff at a high security prison and that as a result he suffered a broken wrist and a suspected broken nose. Staff said that it had been necessary to use force pre-emptively on Mr P because his aggressive behaviour and failure to follow instructions that morning, made them fear that he was about to assault them.

We found that Mr P had assaulted a member of staff at his previous establishment and had previously made threats to staff at the high security prison. That was clearly unacceptable.

However, we also found that the evidence, including good quality video footage, did not support the officers' accounts that Mr P had behaved in a way that justified the use of force on him prior to the incident he had complained about. We also found that the video evidence did not support the officers' accounts that Mr P failed to comply with staff instructions before force was initiated. We therefore concluded, that it was not necessary for staff to use force when they did. We also concluded that staff had given inaccurate accounts in their 'use of force' statements and in subsequent interviews. We regarded this as a very serious matter.

We were also concerned that, although the governor acted appropriately in commissioning an internal investigation in response to Mr P's complaint, the investigation was not sufficiently thorough or challenging and did not identify that the evidence did not support the accounts given by staff.

We made a large number of recommendations, including that the governor should initiate disciplinary investigations into the actions of staff in using force and providing inaccurate accounts of the incident. The governor accepted these recommendations.

Of course, we have not upheld all the complaints about the use of force that we have investigated. In some cases, we have concluded that the evidence did not support the complaint and the use of force was justified. In other cases, we have concluded that there was insufficient evidence to enable us to uphold such a serious complaint, even on the balance of probabilities.

Whether or not we uphold the complaint about the use of force, we often identify other concerns that lead us to make recommendations for improvement. Typical concerns include: poor oversight by the supervising officer of a planned use of force; a failure to enable the prisoner to report the alleged assault to the police; inadequate, missing or near identical 'use of force' statements by staff; a lack of understanding by healthcare staff of their role during a use of force; a failure to arrange an appropriate medical examination after a use of force; and a failure to commission an internal investigation into the prisoner's complaint, or (as in the case of Mr P) a failure to conduct a sufficiently thorough or challenging investigation.

Complaints from female prisoners

As in previous years, we investigated a disproportionately small number of complaints from the female estate. Although the female estate makes up 5% of the total prison population,[35] it accounts for only 2% of all the complaints we investigated from prisoners. Complaints from the female estate were generally similar to those from the male estate, with property, adjudications, administration and staff behaviour being the largest categories.

"Although the female estate makes up 5% of the total prison population, it accounts for only 2% of all the complaints we investigated from prisoners."

[35] Ministry of Justice (2017) *Prison Population: 31 March 2017.* Accessed online: https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2016

Ms Q complained about the behaviour of prison staff in forcing her to travel in inappropriate transport when she transferred from one prison to another.

Our investigation found that Ms Q had limited mobility as a result of some serious medical conditions. On the day of her transfer she told prison staff that she would be unable to travel in a standard cellular van and that special travel arrangements had always been made for her in the past. However, healthcare staff had assessed her as fit to travel, so prison staff told her that she had to travel in the van. The journey took two hours and 40 minutes. Her medical records show that she was very distressed and in considerable pain when she arrived at her new prison and spent the night in their healthcare centre.

We concluded that it had not been unreasonable for prison staff to rely on the advice they were given by healthcare staff. However, we were concerned that the nurse who had assessed Ms Q as fit to travel did not appear to have taken into account the effect that a long journey in a cellular van was likely to have on her disability. Being fit to travel in general, and being fit to travel for two hours and 40 minutes in cramped conditions, are two different things. As the clinical judgement of medical professionals is outside our remit, we recommended that the governor of the sending prison share our report with the healthcare manager, and agree changes with him or her to the way pre-transfer healthcare assessments are conducted.

Complaints from those under 21

As in previous years, we investigated a disproportionately small number of complaints from those under 21:[36] they accounted for only 28 of the 2,313 complaints we investigated. When young people did complain, the most frequent topics were property, staff behaviour and the regime. Among them were some serious complaints about segregation and closed visits, such as the case of Mr G described above.

“When young people did complain, the most frequent topics were property, staff behaviour and the regime. Among them were some serious complaints about segregation and closed visits.”

[36] Complaints from those in the under 21 estate made up 1% of all complaints investigated, yet this age group accounts for 6% of the total prison population (*Ibid*).

Another serious case was that of R who complained that his parents had been banned from visiting and telephoning him when he was 17 and 18. Contact with family is particularly important for children and young people and, on the face of it, the restrictions placed on R appeared to be excessive. However, when we investigated, we found that the circumstances were exceptional: we were satisfied that that the bans were justified on the basis of a considerable body of persuasive intelligence that R's parents were smuggling drugs and other contraband to him. Indeed, we thought it could have been argued that the governor would have been failing in his duty to safeguard the welfare of R and other young people if he had not taken steps to prevent what appeared to be a continuing and fixed intention by R's parents to traffic contraband into the young offender institution. It was a depressing fact that R's parents were clearly not acting in their child's best interests.

We were satisfied that the bans did not have a disproportionate impact on R. While he was under 18 he continued to have visits from one parent and telephone contact with both parents. After he turned 18, both parents were banned from visiting but he had visits from other close family members and, apart from a brief period, he also had telephone contact with both parents.

Although we did not uphold the substantive elements of R's complaint, we did have some concerns. Given R's age, we thought that closed visits should have been considered as an alternative to a total ban. We were surprised to learn that the young offender institution had no facilities for closed visits and recommended that this should be remedied. There was also a period of nine days when R was not able to receive visits from his parents or to contact them by phone. Again, given R's age, we did not think this was appropriate and we considered that, although telephone restrictions were justified, they should always have taken the form of supervised telephone calls rather than a complete ban.

A different issue was raised by 19-year-old Mr S, who complained that his life had been put in danger by being made to share a cell with a high-risk young offender. He asked for compensation.

Our investigation found that Mr S and the other young offender had shared a cell for four days at their previous young offender institution. When they transferred together to a new young offender institution, Mr S asked if they could share a cell again. He was told they could not because the other young offender had been assessed as being too high-risk for cell sharing.

It was clear that Mr S had not come to any harm while he was sharing a cell with the other young offender and that he had in fact been keen to continue sharing a cell with him when they arrived at the second young offender institution. In the light of this, we did not consider that Mr S had suffered any distress or fear for his safety. We did not, therefore, consider that compensation was merited.

However, our investigation also found that the first young offender institution had not followed mandatory national policy[37] when they conducted the other young offender's cell sharing risk assessment (CSRA). In particular, they had not accessed his police national computer (PNC) records to check his offending history and the CSRA had not been authorised by a manager. The second young offender institution had checked his PNC records and as a result, a manager had assessed him as high-risk.

The potential consequences of assessing a prisoner or young offender's risk incorrectly can be extremely serious, and we were very concerned that the first young offender institution's failure to follow mandatory policy instructions could have endangered other young people. We recommended that the governor of the young offender institution should ensure that staff followed the correct procedures in future.

[37] PSI 20/2015 (Cell sharing).

Complaints from immigration detainees

We investigated only 16 complaints from immigration detainees. Most were about property or staff behaviour.

Mr T complained that three escort staff remained in the room when he was taken to hospital from an immigration removal centre.

We take the view that, where the degree of risk and practicalities allow, detainees – like prisoners – should be able to see medical professionals in private without escort staff present. In Mr T's case, we considered that it was reasonable for the immigration removal centre to have taken a cautious approach for the first hospital visit, on the grounds that Mr T had only recently arrived at the immigration removal centre and they knew very little about him or the risks he might pose.

However, we considered that the immigration removal centre's risk assessments for the second and third visits were inadequate and did not provide sufficient justification or explanation for the presence of three officers in the room while Mr T was being examined and treated. At the very least Mr T should have been told that he could ask to see medical staff privately and that, if he did so, a closet chain would be used.

We recommended that Mr T receive an apology and that the Home Office revise the relevant Detention Services Order (DSO)[38] to include specific instruction on the need to facilitate medical confidentiality during escorts for medical examinations and treatment, subject to a well-reasoned risk assessment.

[38] DSO 07/2016 (Risk assessment guidance).

Complaints from probation supervisees

This year, only 12% of complaints from probation supervisees were assessed as eligible for investigation (compared with 54% of complaints from prisoners and 53% of complaints from immigration detainees). Although the eligibility rate of complaints from probation supervisees has always been lower than that of other groups, it has dropped to an all-time low since the changes to probation and the establishment of the community rehabilitation companies (CRCs). We continue to receive telephone calls from supervisees who want to complain to or about a CRC but cannot find any information on how to do this. The Ombudsman has formally raised this issue with HM Prison and Probation Service.

“We continue to receive telephone calls from supervisees who want to complain to or about a CRC but cannot find any information on how to do this. The Ombudsman has formally raised this issue with HM Prison and Probation Service.”

Of the 31 probation complaints completed, many (as in previous years) were about the behaviour of the complainant's offender manager or about the content of reports written on the complainant, or both.

A typical example was the case of Mr U, who complained about various aspects of the service he received from the National Probation Service. We found that while Mr U was in prison he had had four offender managers (probation officers) in the space of two years and had not met any of them; that his most recent offender manager had made a number of appointments to visit him before his release and had cancelled them all; and that his OASys (risk assessment) report had been completed late.

We considered that these were serious failings and should have been properly acknowledged at a senior level. We also considered that some of the judgements the offender manager had made in the risk assessment had not been supported by evidence (although we did not uphold some of Mr U's complaints about the offender manager's behaviour towards him in the community). We recommended that a senior manager should apologise to Mr U for the poor service he had received, and should arrange for the risk assessment to be revisited.

Learning lessons from PPO investigations

The Prisons and Probation Ombudsman (PPO) undertakes investigations into both deaths in custody and complaints and makes hundreds of recommendations to the services in remit every year. Frequently, these recommendations are not made in isolation – if we identify a particular issue at an establishment, it is unlikely to be unique to them. Because of this, establishments can learn from the practice of others, addressing any concerns before they become the subject of an investigation. The learning lessons team at the PPO identifies collective learning from our investigations on both sides of the office. The team collects standardised information about investigations, and identifies common themes and trends. Our learning lessons publications, along with our annual seminars, synthesise these themes and trends into learning for the services we investigate.

In 2016–17, we published six learning lessons bulletins. The first, published in May 2016, focused on complaints about the use of force in prisons, and identified six lessons that prisons can learn from our investigations. The lessons built on learning from a previous publication with the same theme, published in January 2014. In this more recent publication, we made recommendations about de-escalation and the arrival of control and restraint teams, briefing these teams about likely risks, the role of the supervising officer, avoiding one-on-one incidents, ensuring meaningful examinations by healthcare professionals following a use of force, and writing use of force statements independently.

In July 2016, we published a bulletin summarising investigations about prisoners with dementia. In recent years, we have investigated a few deaths where the prisoners already had dementia at the time they were sent to prison, and others who developed dementia during their sentence. This publication identified six lessons about support for decision-making, coordination of care, sharing best practice across prisons, appropriate training for prison carers and having proper safeguards in place, appropriate risk assessments for restraints, and reasonable adjustments when facilitating family involvement.

This was followed in September 2016 by a bulletin outlining lessons learned from our investigations into homicides in custody. This was the second bulletin focusing on deaths of this nature, the first having been published in December 2013. This publication emphasised the need to better manage violence and debt in prison, particularly where it related to new psychoactive substances. It also pointed out the need for careful management of prisoners who are at a known risk from others, and the need to ensure prisons know how to respond when they have an apparent homicide. While homicides in prison are still thankfully rare, we can still do more to prevent them from happening, and respond accordingly if or when they do; this bulletin identifies lessons to help prisons achieve this.

Our annual learning lessons seminar series was held in September 2016 at the Prison and Probation Service college, Newbold Revel. The seminars spanned three days, with one day each focusing on naturally caused deaths in custody, self-inflicted deaths in custody, and complaints. More than 100 delegates from the services in remit attended to hear about recent case studies, learn about the lessons identified as a result of our investigations, share best practices, and discuss the barriers to implementing our recommendations.

Our first publication of 2017 outlined lessons learned from investigations into complaints from transgender prisoners and investigations into deaths in custody of transgender prisoners. It set out guidance on locating prisoners, multidisciplinary ACCT reviews, thoroughly investigating allegations of transphobic bullying, having regular and meaningful contact with transgender prisoners and ensuring local policies are in line with national guidance. It offers advice for making reasonable adjustments to allow transgender prisoners to live safely in their gender. The bulletin enforces and closely follows the updated HMPPS Instructions on the care and management of transgender offenders (PSI 17/2016 and Probation Instruction 16/2016), and we note that a number of the lessons we outlined are reflected in the new Instructions.

The penultimate bulletin of 2016–17 focused on complaints from young people in custody. We have previously noted that we receive few complaints from young people in custody (and a March 2015 publication investigated why this might be). However, the complaints we do receive from this group tend to be quite serious. In this publication, we offered a number of lessons that could help secure training centres and young offender institutions avoid complaints from young people in the first place. We highlighted the need to encourage young people to seek legal advice in advance of adjudication hearings, for use of segregation to be linked to a clear and consistent intervention strategy to help the young person modify their behaviour, and to ensure that young people are not effectively put into segregation without due process. We also offered a number of lessons with respect to the use of force on young people, which includes the use of body worn cameras, and the necessity of a debrief following incidents where force is used.

Most recently, prompted by a rise in deaths of female prisoners in custody, we published a bulletin about our investigations into self-inflicted deaths of female prisoners. Many of the lessons that we identified did not differ much from similar deaths in the male estate. However, given the aforementioned rise, these recommendations were worth re-emphasising. The publication set out lessons about identifying, monitoring and acting on risk; the role of mental health services; bullying; the implementation of the ACCT process; and about emergency response to a self-inflicted death.

These publications continue to attract a wide and varied following, from those who work with or within the prison system, to the public more broadly. Ultimately, we hope these publications continue to fulfil their aim: to promote safer and fairer custody and offender supervision.

Appendices

Statistical tables

The PPO does not determine the cause of death. Deaths are categorised into classifications for allocation and statistical purposes based on information available at the time. Classifications may change during the course of an investigation, however they are not altered following the conclusion of the inquest.

Fatal incident investigations started	Total 2015/16	% of total (15/16)	Total 2016/17	% of total (16/17)	Change 15/16–16/17	% change year on year
Natural	175	58%	208	58%	33	19%
Self-inflicted	104	34%	115	32%	11	11%
Other non-natural**	19	6%	16	4%	-3	*
Homicide	6	2%	4	1%	-2	*
Awaiting classification	0	0%	18	5%	18	*
Total	**304**	**100%**	**361**	**100%**	**57**	**19%**

* The numbers are too small for the % change to be a meaningful indicator.

** Other non-natural includes drug-related deaths, accidents and deaths where post-mortem and toxicology reports have been unable to establish cause of death.

Fatal incident investigations started	Total 2015/16	% of total (15/16)	Total 2016/17	% of total (16/17)	Change 15/16–16/17	% change year on year
Male prisoners (21 and over)	271	89%	318	88%	47	17%
Female prisoners** (21 and over)	11	4%	23	6%	12	109%
Under 21 males	7	2%	4	1%	-3	*
Under 21 females	0	0%	1	0%	1	*
Male approved premises residents	12	4%	9	2%	-3	*
Female approved premises residents	0	0%	2	1%	2	*
Male IRC residents	3	1%	3	1%	0	*
Female IRC residents	0	0%	0	0%	0	*
Male discretionary cases	0	0%	1	0%	1	*
Female discretionary cases	0	0%	0	0%	0	*
Total	**304**	**100%**	**361**	**100%*** **	**57**	**19%**

* The numbers are too small for the % change to be a meaningful indicator.

** Includes male to female transgender prisoners. We began an investigation into the death of two transgender prisoners in 2015–16 and four in 2016–17.

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

Fatal incident investigations started	Natural	Self-inflicted	Other non-natural*	Homicide	Awaiting classification	Total
Male prisoners (21 and over)	196	99	6	3	14	318
Female prisoners** (21 and over)	7	10	6	0	0	23
Under 21 males	0	2	1	0	1	4
Under 21 females	0	1	0	0	0	1
Male approved premises residents	3	1	3	0	2	9
Female approved premises residents	1	0	0	0	1	2
Male IRC residents	1	1	0	1	0	3
Female IRC residents	0	0	0	0	0	0
Male discretionary cases	0	1	0	0	0	1
Female discretionary cases	0	0	0	0	0	0
Total	**208**	**115**	**16**	**4**	**18**	**361**

* Other non-natural includes drug-related deaths, accidents and deaths where post-mortem and toxicology reports have been unable to establish cause of death.

** Includes male to female transgender prisoners. We began an investigation into the deaths of two transgender prisoners in 2015–16 and four in 2016–17.

Fatal incident reports issued	Total 2015/16	% in time*	Total 2016/17	% in time*	Change 15/16–16/17 (volume)	% change year on year (volume)
Initial reports	284	100%	324	100%	40	14%
Final reports	261	82%	322	87%	61	23%
Reports published on website	258	N/A	284	N/A	26	10%

* In time for initial reports is 20 weeks for natural causes deaths and 26 weeks for all others (including those that are unclassified at the time of notification). In time for final reports is 12 weeks following the initial.

Prison fatal incident investigations started in 2016–17

Prisons	Natural	Self-inflicted	Other non-natural*	Homicide	Awaiting classification	Total
Exeter	9	4	0	0	0	13
Woodhill	6	5	0	0	0	11
Altcourse	6	2	0	0	0	8
Birmingham	7	1	0	0	0	8
Durham	6	2	0	0	0	8
Elmley	6	2	0	0	0	8
Littlehey	8	0	0	0	0	8
Wakefield	8	0	0	0	0	8
Eastwood Park	3	3	1	0	0	7
Leeds	5	2	0	0	0	7
Lewes	6	1	0	0	0	7
Liverpool	3	4	0	0	0	7
Manchester	4	3	0	0	0	7
Oakwood	6	0	0	0	1	7
Parc	5	2	0	0	0	7
Bedford	1	5	0	0	0	6
Bristol	2	4	0	0	0	6
Hull	4	2	0	0	0	6
Lincoln	3	2	0	0	1	6
Norwich	5	1	0	0	0	6
Pentonville	2	3	0	1	0	6
Wymott	6	0	0	0	0	6
Cardiff	4	1	0	0	0	5
Doncaster	3	2	0	0	0	5
Garth	2	2	1	0	0	5
Hewell	3	1	1	0	0	5

Prisons	Natural	Self-inflicted	Other non-natural*	Homicide	Awaiting classification	Total
Moorland	3	2	0	0	0	5
Nottingham	1	4	0	0	0	5
Rye Hill	5	0	0	0	0	5
Thameside	5	0	0	0	0	5
Whatton	5	0	0	0	0	5
Wormwood Scrubs	2	2	0	0	1	5
Belmarsh	2	2	0	0	0	4
Channings Wood	2	2	0	0	0	4
Dartmoor	3	1	0	0	0	4
Gartree	2	1	1	0	0	4
Lindholme	1	3	0	0	0	4
Northumberland	2	2	0	0	0	4
Peterborough	2	0	2	0	0	4
Risley	2	1	0	0	1	4
Swaleside	1	3	0	0	0	4
Winchester	3	1	0	0	0	4
Ashfield	2	0	0	0	1	3
Bullingdon	1	1	1	0	0	3
Chelmsford	1	1	0	0	1	3
Full Sutton	3	0	0	0	0	3
Holme House	2	1	0	0	0	3
Humber	0	3	0	0	0	3
Isle of Wight	3	0	0	0	0	3
Leyhill	3	0	0	0	0	3
New Hall	0	1	2	0	0	3
Preston	2	1	0	0	0	3
Stafford	3	0	0	0	0	3

Prisons	Natural	Self-inflicted	Other non-natural*	Homicide	Awaiting classification	Total
Swansea	0	3	0	0	0	3
Wandsworth	1	2	0	0	0	3
Whitemoor	1	2	0	0	0	3
Bure	2	0	0	0	0	2
Featherstone	1	1	0	0	0	2
Forest Bank	1	0	0	0	1	2
Foston Hall	0	2	0	0	0	2
Haverigg	0	1	0	0	1	2
Hindley	1	1	0	0	0	2
Long Lartin	0	0	0	1	1	2
Lowdham Grange	0	1	0	0	1	2
North Sea Camp	2	0	0	0	0	2
Sudbury	1	0	0	0	1	2
The Mount	1	1	0	0	0	2
Wayland	0	2	0	0	0	2
Bronzefield	0	0	1	0	0	1
Buckley Hall	0	0	0	0	1	1
Coldingley	0	0	0	1	0	1
Downview	0	1	0	0	0	1
Drake Hall	0	1	0	0	0	1
Erlestoke	1	0	0	0	0	1
Frankland	1	0	0	0	0	1
Glen Parva	0	1	0	0	0	1
Grendon/Springhill	1	0	0	0	0	1
Guys Marsh	0	0	0	0	1	1
Hatfield	0	0	1	0	0	1
Highpoint	0	0	1	0	0	1

Prisons	Natural	Self-inflicted	Other non-natural*	Homicide	Awaiting classification	Total
Huntercombe	0	1	0	0	0	1
Kirkham	1	0	0	0	0	1
Leicester	0	1	0	0	0	1
Onley	1	0	0	0	0	1
Portland	0	1	0	0	0	1
Stocken	1	0	0	0	0	1
Stoke Heath	0	0	0	0	1	1
Styal	0	1	0	0	0	1
Usk and Prescoed	1	0	0	0	0	1
Warren Hill	1	0	0	0	0	1
Total	**203**	**109**	**12**	**3**	**14**	**341**

* Other non-natural includes drug-related deaths, accidents and deaths where post-mortem and toxicology reports have been unable to establish cause of death.

IRC fatal incident investigations started in 2016–17

IRCs	Natural	Self-inflicted	Other non-natural*	Homicide	Awaiting classification	Total
Colnbrook	0	0	0	1	0	1
Morton Hall	0	1	0	0	0	1
The Verne	1	0	0	0	0	1
Total	**1**	**1**	**0**	**1**	**0**	**3**

* Other non-natural includes drug-related deaths, accidents and deaths where post-mortem and toxicology reports have been unable to establish cause of death.

Approved premises fatal incident investigations started in 2016–17

Approved premises	Natural	Self-inflicted	Other non-natural*	Homicide	Awaiting classification	Total
Bedford	1	0	0	0	0	1
Howard House	0	0	1	0	0	1
Luton	1	0	0	0	0	1
Manor Lodge	1	0	0	0	0	1
Ripon House	0	0	0	0	1	1
South View	0	0	1	0	0	1
St Josephs	0	0	0	0	1	1
The Crescent	1	0	0	0	0	1
The Pines	0	1	0	0	0	1
Westbourne House	0	0	1	0	0	1
Westgate	0	0	0	0	1	1
Total	**4**	**1**	**3**	**0**	**3**	**11**

* Other non-natural includes drug-related deaths, accidents and deaths where post-mortem and toxicology reports have been unable to establish cause of death.

Establishments for under 21s – fatal incident investigations started in 2016–17

Establishments for under 21s	Natural	Self-inflicted	Other non-natural*	Homicide	Awaiting classification	Total
Aycliffe**	0	1	0	0	0	1
Hillside**	0	0	0	0	1	1
Chelmsford	0	1	0	0	0	1
Deerbolt	0	1	0	0	0	1
Hindley	0	0	1	0	0	1
Total	**0**	**3**	**1**	**0**	**1**	**5**

* Other non-natural includes drug-related deaths, accidents and deaths where post-mortem and toxicology reports have been unable to establish cause of death.

** Aycliffe and Hillside are both secure children's homes.

Discretionary fatal incident investigations started in 2016–17

Discretionary	Natural	Self-inflicted	Other non-natural*	Homicide	Awaiting classification	Total
Post-release	0	1	0	0	0	1
Total	**0**	**1**	**0**	**0**	**0**	**1**

* Other non-natural includes drug-related deaths, accidents and deaths where post-mortem and toxicology reports have been unable to establish cause of death.

Complaints

Received	Total 2015/16	% of total (15/16)	Total 2016/17	% of total (16/17)	Change 15/16–16/17	% change year on year
Prison	4,397	92%	4,657	93%	260	6%
Probation	323	7%	315	6%	-8	-2%
Immigration detention	58	1%	38	1%	-20	-34%
Secure training centre	3	<1%	0	0%	-3	*
Total	**4,781**	**100%**	**5,010**	**100%**	**229**	**5%**

* The numbers are too small for the % change to be meaningful.

Complaints accepted for investigation	Total 2015/16	% of total (15/16)	Total 2016/17	% of total (16/17)	Change 15/16–16/17	% change year on year
Prison	2,288	97%	2,505	98%	217	9%
Probation	38	2%	43	2%	5	13%
Immigration detention	30	1%	20	1%	-10	-33%
Secure training centre	1	<1%	0	0%	-1	*
Total	**2,357**	**100%**	**2,568**	**100%****	**211**	**9%**

* The numbers are too small for the % change to be meaningful.

** Due to rounding some totals may not add up to 100%.

Complaints investigations completed	Total 2015/16	% of total (15/16)	Total 2016/17	% of total (16/17)	Change 15/16–16/17	% change year on year
Prison	2,215	97%	2,265	98%	50	2%
Probation	43	2%	31	1%	-12	-28%
Immigration detention	30	1%	16	1%	-14	-47%
Secure training centre	2	<1%	1	0%	-1	*
Total	**2,290**	**100%**	**2,313**	**100%****	**23**	**1%**

* The numbers are too small for the % change to be meaningful.

** Due to rounding some totals may not add up to 100%.

Prison complainants 2016/17 (completed complaints)	Number of complainants	% of complainants	Number of complaints	% of complaints
Male prison estate	1,449	99%	2,230	98%
Female prison estate	16	1%	35	2%
Total	**1,465**	**100%**	**2,265**	**100%**

Complaints completed per prison complainant (2016/17)	Number of complainants	% of complainants	Number of complaints	% of complaints
11+	15	1%	241	11%
6 to 10	27	2%	198	9%
2 to 5	258	18%	661	29%
1	1,165	80%	1,165	51%
Total	**1,465**	**100%**	**2,265**	**100%**

Categories of complaints completed 2016–17

Complaint category	Not upheld	Upheld	Total	Uphold rate*
Property	287	373	660	57%
Administration	149	115	264	44%
Staff behaviour	128	51	179	28%
Adjudications	111	24	135	18%
IEP	88	42	130	32%
Regime	78	44	122	36%
Categorisation	93	26	119	22%
Work and pay	65	41	106	39%
Letters	66	35	101	35%
Visits	46	22	68	32%
Money	44	23	67	34%
Transfers	49	10	59	17%
Accommodation	35	13	48	27%
Probation	42	6	48	13%
HDC	36	2	38	5%
Prisoners	19	16	35	46%
Equalities	14	12	26	46%
Security	20	5	25	20%
Phone calls	13	10	23	43%
Food	15	6	21	29%
Resettlement	11	4	15	*
Medical**	7	5	12	*

Complaint category	Not upheld	Upheld	Total	Uphold rate*
Escorts	4	0	4	*
Legal	3	1	4	*
Parole	4	0	4	*
Total	**1,427**	**886**	**2,313**	**38%**

* Only given where 20 or more complaints were completed.

** Complaints about the clinical judgements of medical professionals are outside the Ombudsman's remit. Complaints about medical treatment and facilities are dealt with through the standard NHS complaints process and referred to the PHSO where required, rather than the PPO. The Ombudsman, therefore, only deals with complaints about matters which are under the control of prisons or the other services in remit (such as escorts to hospital appointments).

Prison complaints completed 2016–17

Prison	Upheld	Not upheld	Total	Uphold rate*	Population**	Upheld complaints per 100 prisoners
Wakefield	49	86	135	36%	747	6.6
Whitemoor	50	68	118	42%	435	11.5
Long Lartin	27	77	104	26%	518	5.2
Frankland	19	71	90	21%	811	2.3
Full Sutton	22	68	90	24%	579	3.8
Isle of Wight	24	49	73	33%	1,078	2.2
Lowdham Grange	15	47	62	24%	916	1.6
Swaleside	22	36	58	38%	1,063	2.1
Woodhill	18	30	48	38%	676	2.7
Rye Hill	13	33	46	28%	659	2.0
Belmarsh	26	19	45	58%	837	3.1
Nottingham	19	18	37	51%	1,005	1.9
Parc	9	28	37	24%	1,691	0.5
Gartree	17	19	36	47%	706	2.4
High Down	15	21	36	42%	1,001	1.5
Highpoint North/ South	16	20	36	44%	1,298	1.2
The Mount	17	19	36	47%	1,013	1.7
Garth	14	20	34	41%	849	1.6
Oakwood	7	26	33	21%	1,983	0.4
Dovegate	18	14	32	56%	1,093	1.6
Littlehey	15	17	32	47%	1,211	1.2
Huntercombe	9	22	31	29%	475	1.9
Manchester	10	20	30	33%	1,030	1.0
Wymott	11	18	29	38%	1,158	0.9
Elmley	14	13	27	52%	1,235	1.1
Moorland	10	17	27	37%	999	1.0

Prison	Upheld	Not upheld	Total	Uphold rate*	Population**	Upheld complaints per 100 prisoners
Lincoln	10	16	26	38%	653	1.5
Ranby	6	19	25	24%	1,046	0.6
Wandsworth	13	12	25	52%	1,560	0.8
Humber	7	17	24	29%	1,066	0.7
Whatton	14	10	24	58%	838	1.7
Ashfield	8	15	23	35%	410	2.0
Coldingley	12	11	23	52%	511	2.3
Hewell	11	12	23	48%	1,170	0.9
Lewes	7	16	23	30%	584	1.2
Bure	4	18	22	18%	642	0.6
Hull	14	8	22	64%	1,037	1.4
Lindholme	13	9	22	59%	999	1.3
Stocken	12	10	22	55%	837	1.4
Peterborough	10	11	21	48%	1,269	0.8
Bullingdon	11	9	20	55%	1,101	1.0
Wayland	5	14	19	*	943	0.5
Doncaster	6	12	18	*	1,144	0.5
Dartmoor	5	12	17	*	634	0.8
Risley	9	8	17	*	1,110	0.8
Thameside	8	9	17	*	1,212	0.7
Buckley Hall	3	13	16	*	458	0.7
Erlestoke	4	12	16	*	387	1.0
Ford	7	8	15	*	535	1.3
Bristol	10	4	14	*	552	1.8
Onley	8	6	14	*	729	1.1
Pentonville	8	6	14	*	1,260	0.6

Prison	Upheld	Not upheld	Total	Uphold rate*	Population**	Upheld complaints per 100 prisoners
Stafford	5	9	14	*	747	0.7
Wealstun	3	11	14	*	829	0.4
Altcourse	7	6	13	*	1,127	0.6
Grendon/Springhill	4	9	13	*	548	0.7
Send	3	10	13	*	278	1.1
Channings Wood	5	7	12	*	693	0.7
Liverpool	5	7	12	*	1,092	0.5
Northumberland	7	5	12	*	1,342	0.5
Birmingham	6	5	11	*	911	0.7
Featherstone	4	7	11	*	638	0.6
Holme House	2	9	11	*	1,204	0.2
Stoke Heath	4	7	11	*	768	0.5
Forest Bank	2	8	10	*	1,450	0.1
Rochester	4	6	10	*	729	0.5
Guys Marsh	6	3	9	*	544	1.1
Leeds	4	5	9	*	1,166	0.3
Leyhill	5	4	9	*	510	1.0
North Sea Camp	3	5	8	*	397	0.8
Winchester	6	2	8	*	653	0.9
Wormwood Scrubs	5	3	8	*	1,258	0.4
Foston Hall	6	1	7	*	328	1.8
Maidstone	2	5	7	*	605	0.3
Sudbury	4	3	7	*	543	0.7
Aylesbury	5	1	6	*	430	1.2
Feltham	1	5	6	*	496	0.2
Leicester	3	3	6	*	314	1.0
Preston	5	1	6	*	725	0.7

Prison	Upheld	Not upheld	Total	Uphold rate*	Population**	Upheld complaints per 100 prisoners
Thorn Cross	3	3	6	*	384	0.8
Hatfield	1	4	5	*	338	0.3
Haverigg	2	3	5	*	280	0.7
Kirkham	0	5	5	*	623	0.0
Lancaster Farms	1	4	5	*	549	0.2
Low Newton	3	2	5	*	327	0.9
New Hall	3	2	5	*	407	0.7
Bedford	2	2	4	*	241	0.8
Bronzefield	2	2	4	*	554	0.4
Drake Hall	1	3	4	*	334	0.3
Exeter	4	0	4	*	503	0.8
Glen Parva	3	1	4	*	615	0.5
Kirklevington	1	3	4	*	258	0.4
Norwich	3	1	4	*	747	0.4
Styal	3	1	4	*	453	0.7
Swinfen Hall	2	2	4	*	600	0.3
Warren Hill	1	3	4	*	249	0.4
Askham Grange	0	3	3	*	101	0.0
Brixton	0	3	3	*	707	0.0
Cookham Wood	1	2	3	*	167	0.6
Durham	2	1	3	*	958	0.2
Hindley	2	1	3	*	568	0.4
Hollesley Bay	2	1	3	*	464	0.4
Portland	2	1	3	*	512	0.4
Wetherby	1	2	3	*	251	0.4
Cardiff	1	1	2	*	782	0.1
Eastwood Park	1	1	2	*	397	0.3

Prison	Upheld	Not upheld	Total	Uphold rate*	Population**	Upheld complaints per 100 prisoners
Holloway	1	1	2	*	***	***
Isis	1	1	2	*	617	0.2
Standford Hill	2	0	2	*	460	0.4
Swansea	0	2	2	*	447	0.0
Usk and Prescoed	0	2	2	*	533	0.0
Blantyre House	0	1	1	*	***	***
Brinsford	0	1	1	*	485	0.0
Chelmsford	1	0	1	*	724	0.1
East Sutton Park	1	0	1	*	97	1.0
Total	**880**	**1,385**	**2,265**	**39%**	**84,664**	**1.0**

* Only given where 20 or more complaints were completed.

** Prison population figures taken from February 2017 monthly population figures: https://www.gov.uk/government/statistics/prison-population-figures-2017.

*** Holloway closed in July 2016 and Blantyre House is empty due to temporary closure.

IRC complaints completed 2016–17

IRCs	Upheld	Not upheld	Total	Uphold rate*	Population**	Upheld complaints per 100 residents
Harmondsworth	0	5	5	*	616	0.0
Colnbrook	0	4	4	*	312	0.0
Morton Hall	0	2	2	*	355	0.0
Campsfield House	0	1	1	*	256	0.0
Dover	1	0	1	*	***	***
Dungavel House	0	1	1	*	116	0.0
The Verne	0	1	1	*	420	0.0
Yarl's Wood	1	0	1	*	263	0.4
Total	**2**	**14**	**16**	*	**1,055**	**0.2**

* Only given where 20 or more complaints were completed.

** IRC population figures taken from October to December 2016 immigration statistics quarterly release figures: https://www.gov.uk/government/statistics/immigration-statistics-october-to-december-2016.

*** Dover IRC has now closed.

Probation complaints completed 2016–17

Probation	Upheld	Not upheld	Total	Uphold rate*
NPS South West & South Central	0	6	6	*
NPS North East	0	5	5	*
NPS North West	0	5	5	*
London Probation Area	1	1	2	*
NPS and Partnerships in Wales	0	2	2	*
NPS Midlands	1	1	2	*
Bedfordshire	0	1	1	*
CRC Cumbria & Lancashire	0	1	1	*
CRC Thames Valley	0	1	1	*
CRC Wales	0	1	1	*
CRC Warks & West Mercia	0	1	1	*
Lancashire	0	1	1	*
NPS London	0	1	1	*
NPS South East & Eastern	0	1	1	*
Staffordshire and West Midlands	1	0	1	*
Total	**3**	**28**	**31**	**10%**

* Only given where 20 or more complaints were completed.

STC complaints completed 2016–17

STC	Upheld	Not upheld	Total	Population**	Uphold rate*
Hassockfield***	1	0	1	**	*
Total	**1**	**0**	**1**	**	*

* Only given where 20 or more complaints were completed.

** Hassockfield closed in March 2015.

*** This was a historic investigation into events at Hassockfield in 2007 undertaken by exception at the request of the YJB.

Financial data

Finance	2015/16	% of total (15/16)	2016/17	% of total (16/17)	Change 15/16–16/17	% change year on year
Budget allocation	£5,524,000		£5,270,000		-£254,000	-5%
Staffing costs	£5,139,357	95%	£5,141,640	95%	+£2,283	0%
Non-staff costs	£255,715	5%	£277,671	5%	+£21,956	+9%
Total spend	**£5,395,072**	**100%**	**£5,419,311**	**100%**	**+£24,239**	**0%**

Recommendations

The Ombudsman's vision for the organisation is that his 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.

We make recommendations following both complaint and fatal incident investigations. In line with guidance issued by the Ombudsman in 2012, recommendations must be specific, measurable, realistic and time-bound, with tangible outcomes, to structure learning and help reduce the likelihood of repeat failings.

> "...recommendations must be specific, measurable, realistic and time-bound, with tangible outcomes, to structure learning and help reduce the likelihood of repeat failings."

When recommendations are made as a result of a fatal incident investigation, the service in remit is required to confirm whether they accept them. Where recommendations are accepted, there must be an action plan outlining what action will be taken and when, and who will be responsible for the action. For complaints, the organisation is required to confirm whether they accept our recommendations and also to provide evidence of implementation.

Our analysis here shows that, as in previous years, virtually all our recommendations were accepted (although we are still seeking a response on acceptance for around a quarter of cases). In the very few cases where a recommendation was rejected by HM Prison and Probation Service, the Chief Executive will write personally to the Ombudsman with his reasons.

The Prisons and Probation Ombudsman has implemented feedback loops with the two inspectorates relevant to our work, providing independent assessment about what has happened after making our recommendations. HM Inspectorate of Prisons routinely follow up our recommendations following prison fatal incident investigations and they also invite complaint investigators to identify any particular issues they wish to raise about a prison. In 2016–17, we initiated a feedback process with HM Inspectorate of Probation to gather feedback about deaths in and complaints about probation approved premises, and complaints about probation services more broadly.

Individual investigations provide transparency to those affected by a death and a means to obtain redress to complainants. Recommendations also have the potential to ensure that specific lessons are learned, including, sometimes, at national level. We monitor all of the recommendations that we make, enabling us to identify and track areas of concern or interest. They provide an excellent data source for cross-case analysis, which can be disseminated in our learning lessons publications.

> We monitor all of the recommendations that we make, enabling us to identify and track areas of concern or interest."

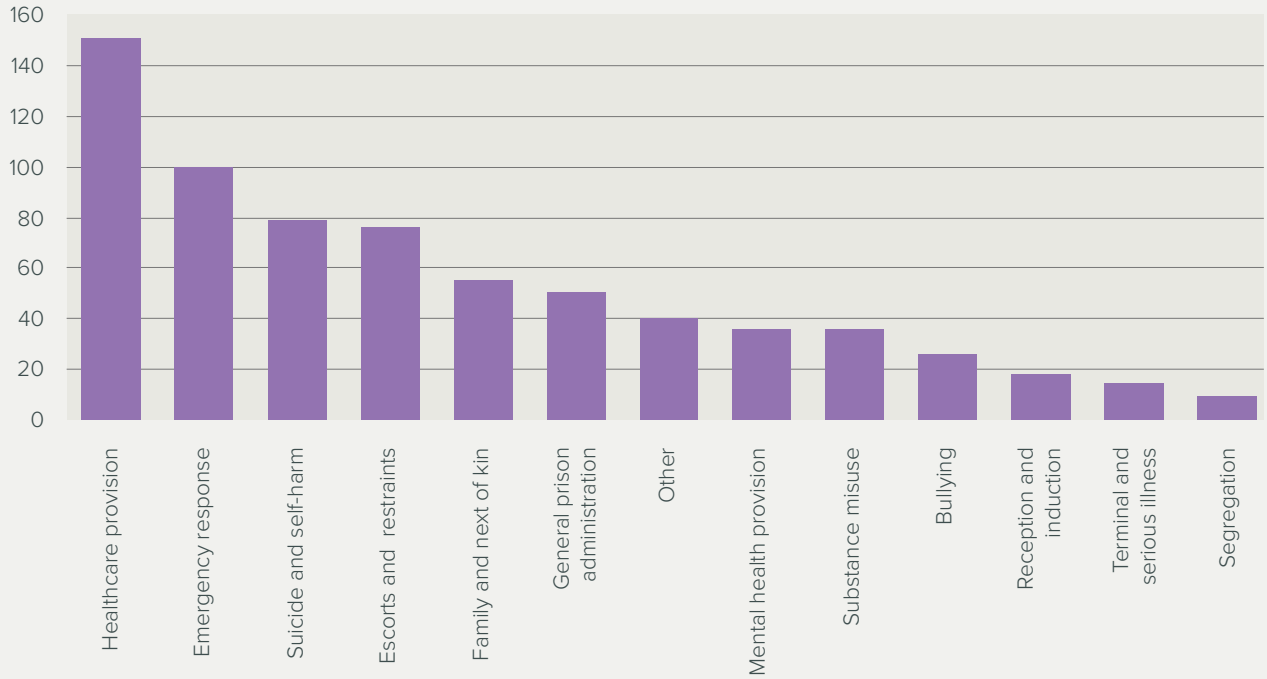
Fatal incidents

- In 2016–17, we made 690 recommendations following deaths in custody. Every one of the recommendations was accepted.
- The main issues that prompted recommendations were: healthcare provision (22%), emergency response (14%), suicide and self-harm prevention (11%) and escorts and restraints (11%).
- Healthcare recommendations related to medical screenings, appointments, assessments and referrals, record keeping and information sharing between professionals to ensure appropriate treatment and continuity of care, as well as appropriate monitoring of those with particular conditions, symptoms or risk factors.
- Emergency response recommendations reiterated the importance of staff understanding and enacting their responsibilities and acting promptly in life-threatening situations. For example, entering cells without delay to remove ligatures and/or commence life-saving treatment, calling the correct emergency codes and ensuring the right medical equipment is brought to the scene. Additionally, many recommendations were made for leaders to remind staff about the circumstances in which resuscitation is appropriate.
- Recommendations concerning self-inflicted deaths often related to the way in which suicide and self-harm prevention procedures had been implemented, mental health provision, or problems with the institution's general administration procedures – particularly those related to safety and wellbeing, such as roll counts, welfare checks and personal officer schemes.

> In 2016–17, we made 690 recommendations following deaths in custody. Every one of the recommendations was accepted."

- Recommendations relating to natural cause deaths most frequently related to problems with healthcare provision, the inappropriate use of restraints, and issues around the family or next of kin.
- A number of national recommendations were made in 2016–17 that sought action beyond the immediate setting where the death occurred. These related to: commissioning of prison health services such as psychiatry or drug detoxification, decision-making around the location of transgender prisoners, transition arrangements for young prisoners moving into adult custody, transfer arrangements for prisoners with particular health needs, and the need for a review of a particular unit within a prison where two deaths had occurred in quick succession.

Recommendations following deaths, by issue



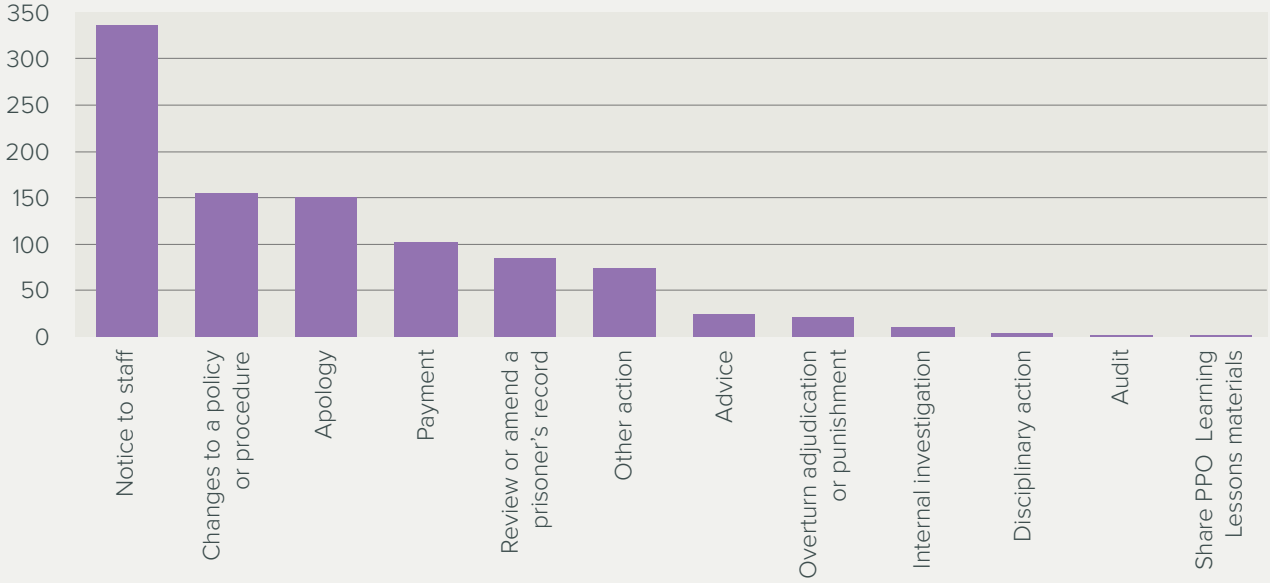
Complaints

- In 2016–17, we made 963 recommendations following investigations into complaints. Of these, just two were rejected, but we are awaiting a response to a large number (27%).

> “In 2016–17, we made 963 recommendations following investigations into complaints. Of these, just two were rejected, but we are awaiting a response to a large number (27%).”

- The most frequent recommendation (35%) was that a governor or director should issue a notice reminding staff to adhere to a policy. This was followed by recommendations for either an apology to be made to the complainant or for a revision to be made to a policy or procedure (both 16%).
- These were followed by recommendations for compensation to be paid (11%) and to review or amend a complainant’s record (9%).
- Recommendations grouped under ‘other’ (8%), incorporated a range of actions including staff training, prison facilities, and issuing notices and information to prisoners.

Recommendations following complaints, by action



- There were three instances where the PPO recommended disciplinary action against staff be initiated. At other times, where incidents fell below the threshold for this type of action, we recommended that managers issue formal advice and guidance to staff, including sharing our investigation findings.

“There were three instances where the PPO recommended disciplinary action against staff be initiated.”

- While the vast majority of recommendations in 2016–17 related to either the individual complainant or local policy, we made 13 recommendations to HM Prison and Probation Service in relation to national policy. These included recommendations to review and/or clarify national guidance, issue advice or reminders to prison governors or clarify expectations, and to establish routes for prisoners in Wales to make complaints about healthcare.

Stakeholder feedback

We routinely collect feedback from our stakeholders in order to understand how they engage with our work, their level of satisfaction, and their opinions as to how we can improve. To that end, the PPO runs four rolling stakeholder surveys to facilitate feedback broadly 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), and;
- those who complain to us (by way of our complainants survey).

We regularly publish this data, and detailed reports from previous years can be found on our website. In the coming year, we intend to integrate these separate publications into one over-arching stakeholder feedback report. Please note that the findings shown here are preliminary. At the time of publication, the data collection periods for some surveys are ongoing – the data shown here is correct at the time of writing, though could change slightly between this publication and the publication of our stakeholder feedback report.

General stakeholder survey

Our general stakeholder survey is usually published at the end of each financial year. It asks a broad range of stakeholders for their feedback on our performance over the previous year across all areas of the office – both our investigations into fatal incidents and complaints, as well as our learning lessons publications.

Responses: 191 people responded to the survey in 2016–17, compared with 131 in the previous year.

Overall satisfaction: The majority of stakeholders involved with investigations throughout the previous year felt positively about their timeliness.

- 52% of those involved with complaint investigations and 73% of those involved with fatal incident investigations reported satisfaction.
- Nearly all respondents (97%) rated the PPO overall as satisfactory or better, a four percentage point increase on last year.

Timeliness:

- Nearly a quarter of respondents who were involved in complaints investigations felt there was an improvement in timeliness this year compared to last. The rest felt there was no change.
- More than a third of those involved in fatal incident investigations felt there was an improvement in timeliness, and over half felt there was no change between this year and last year. One in 10 felt that investigations were slower this year, compared with the last.

Learning Lessons: At the time of the survey (early March) the most widely read learning lessons publication in the previous year was the bulletin on transgender prisoners. More than two-thirds of respondents reported having read it.

Impact: More recently, we have included questions about the perceived impact the PPO has, and to what extent we uphold the values we hope to reinforce with our work:

- The majority of stakeholders felt the PPO is influential (79%) and independent (78%). Although positive, these numbers represent decreases from last year (85% and 92% respectively).

Post-investigation survey

We send our post-investigation survey to liaison officers, establishment governors, and healthcare leads within the establishment, following each fatal incident investigation. We ask that these stakeholders respond to the survey about specific investigations. Additionally, we also survey coroners at the end of the year about their overall experiences with fatal incident investigations. The survey asks questions that help us monitor and improve our fatal incidents investigations: questions about communication, quality of the investigation and resulting report, and what changed as a result of the investigation.

Responses: At the time of writing, we had received 205 responses. This was a slight increase from the previous year, when the survey attracted 193 respondents.

Overall satisfaction: Overall, 77% of respondents reported the quality of the investigation was good or very good, 22% of respondents said the investigation was satisfactory and 1 person reported they felt the investigation was poor.

Communication: We ask all respondents about how satisfied they are with communication from the PPO.

- Of those who responded, 86% were either satisfied or very satisfied with communication, 13% gave a neutral response and only 1% were dissatisfied.

Investigation: We ask respondents about the timeliness of the investigation, whether we understood the system and the issues involved, and whether the correct issues were covered.

- 83% of respondents were satisfied with the time it took to complete an investigation, 15% responded neutrally, and 2% of respondents were dissatisfied with the timeliness of the investigation.
- Nearly all respondents (93%) reported that the PPO investigator understood the system in which they operated and the issues involved in the investigation. Only 7% identified that this understanding could be improved.
- All respondents reported that investigations covered the right issues.

Reports: We also ask governors, healthcare leads, and coroners about the nature and the quality of the reports we issue following the investigation.

- Of those who responded, 94% said that the report we issued met their expectations and 5% said that the report fell short.
- Nearly all stakeholders (98%) reported that PPO reports were either clear or very clear. Only 2% of respondents said reports were not very clear.

Impact: We also collect data on perceptions of our office, and how influential our stakeholders think we are.

- Most respondents (82%) either agreed or strongly agreed that the PPO is influential.
- Similarly, most respondents (83%) agreed or strongly agreed that the PPO is independent.

Bereaved families survey

We also survey families of the deceased following our investigations of deaths in custody. As the response rate is usually low, data collected from these surveys is only published every two years in our bereaved families' survey report. The data reported here is for the collection period April 2015 to March 2017 inclusive. We ask respondents questions about their service from our family liaison officers (FLO), as well as how satisfied they were with our investigation and resulting report.

Responses: We have received 51 responses so far during this data collection period, compared with 69 responses received during the previous collection period.

Overall satisfaction:

- The majority of the respondents (84%) felt the draft report met their expectations. A further 12% reported it partially did. Only 4% felt the report did not meet expectations. This was an improvement from last period where approximately three-quarters of respondents felt the report met expectations.

FLO contact: Our FLOs keep in contact with bereaved families throughout the investigation process, and update them on progress. As such, we ask bereaved families about the amount of contact they have with FLOs.

- 88% of respondents said they received the right amount of contact with the FLO during the investigation. The remaining respondents would have appreciated more.

FLO communication: We also ask about the quality of communication with our FLOs.

- Communication from the FLO was rated positively, with 86% of respondents saying they were satisfied or very satisfied. Only 6% of the sample (three individuals) felt the contact was average and the remaining 8% were dissatisfied.

Impact: As with other surveys, we ask bereaved families to what extent we are upholding our values.

- Bereaved families viewed the PPO positively – 89% of respondents characterised the PPO as independent, and 82% said they think the PPO is influential.

Complainants' survey

We send surveys to those whose complaints we have investigated in the past year – both those whose complaints were upheld, and those whose were not – but also sample those who have contacted us, but whose complaints were ineligible. The data collection period is ongoing at the time of writing, but we summarise several preliminary results below.

Responses: At the time of writing, we had collected 222 responses. This represented 142 complaint investigations – 83 people whose complaints were upheld, and 59 whose complaints were not – and 80 responses from those with ineligible complaints whose complaints were not investigated, but who received letters explaining why.

Quality of investigation: For those with eligible complaints, we asked about their views on the overall quality of the investigation.

- Of those whose complaints were upheld, 56% rated the quality of investigation as either good or very good. This number fell to 19% for those whose complaints were not upheld.

Quality of service: For those whose complaints were ineligible, we asked their opinion about the overall quality of the service they received.

- Of those who received letters explaining their complaint was ineligible, 32% rated the service they received as either good or very good.

Reports and letters: It is important that we communicate clearly and effectively with complainants, and that we write in such a way that our reasoning is understood.

- 85% of respondents whose complaints were upheld said the report they received was either clear or very clear. This number fell to 68% for those whose complaints we had not upheld.
- Of those whose complaints were ineligible, 83% reported that our letter explaining why was clear or very clear.

Outcome: We also survey complainants to ask whether the PPO helped them achieve a satisfactory outcome.

- Of those whose complaints were upheld, 70% agreed that the PPO helped them reach a satisfactory outcome to their complaint. Only 16% of those whose complaints we did not uphold said we helped them achieve a satisfactory outcome.
- Where we do not investigate a complaint, we send a letter explaining the reasons why. This letter will often include advice on other steps the prisoner can take to achieve resolution – for example, by completing the prison's internal complaints process, or sending it to another organisation. We follow up with prisoners to see if this advice helped. Within this group, 22% said the PPO helped them achieve a satisfactory outcome.

Impact: As with other surveys, we ask our complainants for their views on the office and the values that we hope to promote.

- Of those whose complaints were upheld, 69% agreed that the PPO is influential and 62% believed we are independent.
- Of those whose complaints were not upheld, 30% agreed that we are influential and 18% agreed that we are independent.
- Of those whose complaints were ineligible, 35% characterised us as influential and 33% said we are independent.

Performance against business plan 2016–17

Objective 1: Maintain and reinforce our reputation for absolute independence

Key deliverable	Measure of success	Lead	End-year update
1. Work with the Ministry of Justice to secure a statutory footing for the PPO at the next legislative opportunity	Consideration by Parliament in the next relevant Bill with resultant change in law	Ombudsman	**Not achieved** The Prisons and Courts Bill contained clauses to put the PPO on a statutory footing. The Bill did not progress during the session due to the general election being called
2. Work with the Ministry of Justice to secure revised PPO Terms of Reference that enhance our independence and clarify our remit and operational scope by end September 2016	Agreed Terms of Reference [as endorsed by Ministers and the PPO]	Ombudsman	**Achieved** The Terms of Reference were endorsed and published in April 2017.
3. Increase stakeholders' confidence in the office's independence	Achieve a positive response to the independence question in stakeholder surveys to be conducted by March 2017	Head of Learning Lessons	**Achieved** Increase from 52% thinking PPO very independent in 2014–15 to 58% in 2015–16

Objective 2: Improve the quality and timeliness of our investigations and resulting reports ensuring a robust and proportionate approach.

Key deliverable	Measure of success	Lead	End-year update
1. Apply a continuous improvement approach to the PPO investigation methodology and report production in order to deliver against target by end March 2017	Delivered to time and quality [as endorsed by the PPO]	Ombudsman/Deputy Ombudsmen	**Ongoing** Strategic review of structure of FII team was commissioned and reported in January 2017. Changes implemented from April 2017.
2. Improve the quality and consistency of investigation reports through the development of report templates, better knowledge management and other innovations by end March 2017	Delivered to time and quality [as measured through positive feedback through the surveys from stakeholders]	Ombudsman/ Deputy Ombudsmen: Complaints/Fatal Incidents	**Achieved** Review of FII report formats was commissioned and reported and implemented in January 2017.
Complaints investigations			
3. Determine the eligibility of complaints within 10 working days of receipt	At least 80% delivered to time and quality [as indicated by management information and endorsed by the PPO]	Deputy Ombudsman: Complaints	**Achieved** 82% were completed in time compared with 50% in 2015–16.
4. Provide a draft response to 'serious complaints' (usually allegations of assault) within 26 weeks of accepting the complaint as eligible	At least 70% delivered to time and quality [as indicated by management information and endorsed by the PPO]	Deputy Ombudsman: Complaints	**Not achieved** This year 10% of serious case complaints received a draft response within timescale. Capacity was reduced by unexpected vacancies in-year. Most of the vacancies have now been filled and performance should improve in 2017–18.

Key deliverable	Measure of success	Lead	End-year update
5. Provide a substantive reply to new complaints not identified as serious complaints within 12 weeks of accepting the complaint as eligible	At least 60% delivered to time and quality [as indicated by management information and endorsed by the PPO]	Deputy Ombudsman: Complaints	**Not achieved** 32% of complaints not identified as serious cases were completed within 12 weeks of being made eligible.
Fatal incident investigations			
6. Complete investigations into self-inflicted deaths and distribute the initial report for consultation within 26 weeks of initial notification	At least 70% delivered to time and quality [as indicated by management information and endorsed by the PPO]	Deputy Ombudsman: Fatal Incidents	**Achieved** 2016–17 performance at 100%
7. Complete investigations into deaths due to natural causes and distribute the draft report for consultation within 20 weeks of initial notification	At least 70% delivered to time and quality [as indicated by management information and endorsed by the PPO]	Deputy Ombudsman: Fatal Incidents	**Achieved** 2016–17 performance at 100%
8. Finalise all fatal incident investigation reports within 12 weeks of issue of the draft report	At least 70% delivered to time and quality [as indicated by management information and endorsed by the PPO]	Deputy Ombudsman: Fatal Incidents	**Achieved** 2016–17 performance at 87% compared to 82% for 2015–16

Key deliverable	Measure of success	Lead	End-year update
Fatal incident investigations			
9. Improve rates of positive feedback on the PPO's investigation performance through post-investigation and annual surveys of complainants and other stakeholders. Publish the feedback findings and related actions on the PPO website by October 2016	Delivered to time and quality [as endorsed by the PPO]	Deputy Ombudsmen/ Head of Learning Lessons	**Achieved** Feedback from the PPO post investigation survey and PPO stakeholder survey published in December 2016. 97% of stakeholders rated the PPO overall as satisfactory or better. A four percentage point increase on last year. From the post-investigation survey overall, 87% of respondents reported the quality of the investigation was good or very good.

Objective 3: Improve our influence through the identification and sharing of lessons learned from our investigations.

Key deliverable	Measure of success	Lead	End-year update
1. Undertake a programme of work to increase the implementation and impact of investigation and thematic recommendations by March 2017	High acceptance rate of recommendations, with appropriate action plans put in place by the investigated bodies; PPO challenge and, escalation of rejected recommendations or inadequate responses; high implementation rate of PPO recommendations as measured by HMI Prisons and IMBs on the PPO's behalf during their inspections and visits; and high implementation rate of PPO recommendations as evidenced during PPO fieldwork	Ombudsman/Deputy Ombudsmen	**Ongoing** Virtually all recommendations accepted and relevant action plans put in place. Variable feedback from HMI Prisons on implementation. Engagement and challenge with HMPPS and prisons on repeat recommendations initiated. Further work underway, focusing on engagement with Governors, Deputy Directors of Custody and commissioners. .
2. Hold three Learning Lessons seminars for operational staff from services in remit in September 2016 focused on sharing the learning from investigations of: ■ Self-inflicted deaths ■ Natural causes deaths ■ Complaints	Delivered to time and quality [as endorsed by the PPO and participant feedback]	Ombudsman/Deputy Ombudsmen/ Head of Learning Lessons	**Achieved** Seminars were held in September 2016.

Key deliverable	Measure of success	Lead	End-year update
3. Promote timely learning from individual investigations through the publication of themed Learning Lessons publications for both fatal incidents and complaint investigations	Delivered to time and quality [as measured by the agreed publication timelines and the PPO's endorsement]	Deputy Ombudsman: Learning Lessons & Strategic Support/Head of Learning Lessons	**Achieved** 6 Learning Lessons products were published. These were: *Use of force – further lessons* (May 2016), *Dementia* (July 2016), *Homicides – further lessons* (September 2016), *Transgender Prisoners* (January 2017), *Complaints from young people in custody* (February 2017) and *Self-inflicted deaths among female prisoners* (March 2017).
4. Conduct a full joint thematic with HM Inspectorate of Prisons on redress by end March 2017	Delivered to time and quality [as measured by the respective project plan timelines and the PPO's and HMCIP's endorsement]	Deputy Ombudsman: Learning Lessons & Strategic Support/Head of Learning Lessons	**Ongoing** Delayed due to lack of resources for both HMIP and PPO.
5. Respond to relevant Government and operational policy consultations by March 2017	Delivered to time and quality [as endorsed by the PPO]	Ombudsman\Policy Officer\Head of Learning Lessons	**Ongoing** Examples include submissions to the Justice Select Committee and the PPO's input to the Lammy Review on outcomes for BAME people in the criminal justice system.
6. Identify topics for learning lessons analysis 2017–18 through internal and external consultation on themes by January 2017	Delivered to time and quality [as endorsed by the PPO]	Ombudsman/Head of Learning Lessons	**Ongoing** Some themes identified and agreed for 2017/18. These will now be circulated to key external stakeholders.

Key deliverable	Measure of success	Lead	End-year update
7. Deliver the PPO's communications action plan (see annex to Business Plan 2016/17)	Delivered to time and quality [as defined by stakeholder feedback and endorsed by the PPO]	Ombudsman/All senior staff	**Achieved** (See annex to Business Plan 2016/17).
8. Produce an annual report for April 2015 to March 2016 for publication in September 2016	Delivered to time and quality [as defined by the publication timelines and endorsed by the PPO]	Ombudsman/Deputy Ombudsmen/Head of Learning Lessons	**Achieved** Annual report delivered on time.

Objective 4: Use our resources efficiently and effectively.

Key deliverable	Measure of success	Lead	End-year update
1. Make efficiencies in light of the financial allocation arising from the Spending Review by March 2017	Efficiency Plan designed and delivered. PPO continues to function effectively within budget limits	Ombudsman/Deputy Ombudsmen	**Achieved** The Executive Committee considered where efficiencies could be made, balanced against business needs.
2. Hold three full staff meetings in order to promote training and development and share learning across the office	Delivered to time and quality [as measured by positive feedback on staff evaluation forms]	Ombudsman	**Not achieved** Full staff meetings held in June and November 2016.
3. Devise an action plan in response to findings of People Survey by February 2017	Delivered to time and quality [as measured by the level of response to the actions]	Ombudsman/ Deputy Ombudsman: Learning Lessons & Strategic Support/Staff Engagement Action Group	**Achieved** Action plan developed following full staff meeting in November 2016.
4. Deliver the PPO's equality and diversity action plan (see annex to Business Plan 2016/17)	Delivered to time and quality [as measured through quarterly monitoring by the Equality and Diversity Group]	Ombudsman/Equality and Diversity Group	**Achieved** The Equality and Diversity Group, chaired by the Ombudsman, delivered the equality and diversity action plan.
5. Deliver the PPO's learning and development action plan (see annex to Business Plan 2016/17)	Delivered to time and quality [as measured through improved response to the staff survey on development opportunities]	Head of Strategic Support	**Achieved** (See annex to Business Plan 2016/17).
6. Negotiate appropriate budget allocations based on actual and anticipated changes to workload by March 2017	Delivered to time and quality [as endorsed by the PPO]	Ombudsman/Deputy Ombudsman: Learning Lessons & Strategic Support	**Not achieved** Bid made for an increased allocation due to an increase in demand. Received a flat allocation that did not take account of the rise in demand.

Key deliverable	Measure of success	Lead	End-year update
7. Deliver a replacement case management system which supports an efficient and effective investigation process by March 2017	Delivered to time and quality [as endorsed by the PPO]	Deputy Ombudsman: Learning Lessons & Strategic Support	**Not achieved** The project has been stopped. The PPO is exploring other case management options.
8. Produce the PPO Business Plan 2017–18 by March 2017 and Strategic Plan 2018–21 by March 2017	Delivered to time and quality [as endorsed by the PPO]	Ombudsman/Deputy Ombudsman: Learning Lessons & Strategic Support	**Partly achieved** The publication of the Business Plan was delayed due to the general election and has now been published. The Strategic Plan will be produced by the new Ombudsman once appointed.
9. Review Memoranda of Understanding for all key stakeholders to ensure they promote effective joint working by end March 2017	Delivered to time and quality [as endorsed by the PPO]	Ombudsman/Deputy Ombudsman: Learning Lessons & Strategic Support	**Ongoing** Examples include MoU with the Chief Fire and Rescue Adviser and Inspector (Wales) published in July 2016.

Terms of reference

The Role

1. The Prisons and Probation Ombudsman (PPO) is appointed by the Secretary of State for Justice, following recommendation by the House of Commons Justice Select Committee. The Ombudsman is therefore an administrative appointment. These Terms of Reference represent an agreement between the Ombudsman and the Secretary of State as to the Ombudsman's role.

2. The Ombudsman is wholly independent. This includes independence from Her Majesty's Prison and Probation Service (HMPPS), the National Probation Service for England and Wales and the Community Rehabilitation Companies for England and Wales (probation), any individual Local Authority, the Home Office, the Youth Justice Board (YJB), providers of youth secure accommodation, the Department for Education (DfE), the Department of Health and NHS England.[39] This enables the Ombudsman to execute fair and impartial investigations, making recommendations for change where necessary, without fear or favour. The actual independence of the Ombudsman from the authorities in remit is an absolute and necessary function of the role.

3. The Ombudsman's office is operationally independent of, though it is sponsored by, the Ministry of Justice. The perceived and visible independence of the Ombudsman from the sponsorship body is fundamental to the work of the Ombudsman. No MoJ official may attempt to exert undue influence on the view of the Ombudsman.

4. The bodies subject to investigation by the Prisons and Probation Ombudsman will make sure the requirements of these Terms of Reference are set out clearly to staff in internal policies, procedures and instructions.

Right of access

5. The 'Head' of the relevant authority (or the Secretary of State for Justice, Home Secretary, the Secretary of State for Education or Secretary of State for Health where appropriate) will ensure that the Ombudsman has unfettered access to all relevant material held both in hard copy and electronically. This includes classified material, physical and mental health information, and information originating from or held by other organisations e.g. contractors (or their sub-contractors) providing services to or on behalf of those within remit, if this is required for the purpose of investigations within the Ombudsman's Terms of Reference. The Ombudsman will consider representations as to the necessity of particular information being provided, the means by which

[39] Referred to throughout as 'the authorities'.

provision is achieved and any sensitivity connected with future publication, but the final decision rests with the Ombudsman who will define the documentation required based on the context of the investigation.

6. The Ombudsman and his staff will have access to the premises of the authorities in remit, at times specified by the Ombudsman, for the purpose of conducting interviews with employees, detainees and other individuals, for examining source materials (including those held electronically such as CCTV), and for pursuing other relevant inquiries in connection with investigations within the Ombudsman's Terms of Reference. The Ombudsman will normally arrange such visits in advance.

7. The Ombudsman and his staff have the right to interview all employees, detainees and other individuals as required for the purpose of investigation and will be granted unfettered access to all such individuals.

Reporting Arrangements

8. The Ombudsman will produce and publish an annual report, which the Secretary of State will lay before Parliament. The content of the report will be at the Ombudsman's discretion but will normally include:

   - anonymised examples of complaints investigated;
   - examples of fatal incidents investigated;[40]
   - recommendations made and responses received;
   - a summary of the workload of the office, including the number and types of complaints received, investigated and upheld and the number and types of death notifications received and investigated;
   - the office's success in meeting its performance targets;
   - a summary of the costs of the office.

9. The Ombudsman may publish additional reports on issues relating to his investigations, such as themed learning lessons publications. The Ombudsman may also publish other information as considered appropriate.

[40] Anonymised at the discretion of the Ombudsman.

Matters subject to investigation

10. The Ombudsman will investigate:

    i) decisions and actions (including failures or refusals to act) relating to the management, supervision, care and treatment of prisoners, detainees, or young people in secure accommodation.[41] The Ombudsman's remit does not depend on the authority in remit or their staff, acting or failing to act, or taking decisions, themselves. The Ombudsman will therefore also look at the decisions and actions of contractors and subcontractors and of the servants and agents of the services in remit, including members of the Independent Monitoring Board and other volunteers, where these are relevant to the matter under investigation;

    ii) decisions and actions (including failures or refusals to act) relating to the management, supervision, care and treatment of offenders under probation supervision. The Ombudsman's remit does not depend on HMPPS, the National Probation Service or the Community Rehabilitation Companies, or their staff, acting or failing to act, or taking decisions, themselves. The Ombudsman will therefore also look at the decisions and actions of contractors and sub-contractors and of the servants and agents of HMPPS, the National Probation Service and the Community Rehabilitation Companies, including volunteers and supply chain organisations, where these are relevant to the matter under investigation; and

    iii) decisions and actions (including failures or refusals to act) in relation to the management, supervision, care and treatment of immigration detainees including residents of immigration removal centres, those held in short term holding facilities or pre-departure accommodation, and those under immigration escort. The Ombudsman's remit does not depend on the Home Office, NHS England or their staff, acting or failing to act, or taking decisions, themselves. The Ombudsman will look at the decisions and actions of contractors and sub-contractors and of the servants and agents of the Home Office, including members of the Independent Monitoring Board and other volunteers, where these are relevant to the matter under investigation.

11. In addition, the Ombudsman will have discretion to investigate, to the extent appropriate, other fatal incidents that raise issues about the care provided by the relevant authority in respect of (i) to (iii) above.

[41] The PPO will investigate fatal incidents in secure children's homes (SCHs). This includes fatal incidents of young people placed in SCHs on welfare grounds. The Ombudsman will not investigate complaints from young people in SCHs.

Complaints

12. The Ombudsman's complaints investigations will support the UK's compliance with the requirements of Article 3 (read with Article 1) of the European Convention on Human Rights, specifically by ensuring the independent investigation of allegations of torture, inhumane or degrading treatment or punishment.

13. The aims of the Ombudsman's investigations are to:

    - establish the facts relating to the complaint with particular emphasis on the integrity of the process adopted by the authority in remit and the adequacy of the conclusions reached;
    - examine whether any change in operational methods, policy, practice or management arrangements would help prevent a recurrence;
    - seek to resolve the matter in whatever way the Ombudsman sees fit, including by mediation; and
    - where the complaint is upheld, restore the complainant, as far as is possible, to the position they would have occupied had the event not occurred.

14. The Ombudsman will consider the merits of the complaint as well as the procedures involved.

Persons able to complain

15. The Ombudsman will investigate eligible complaints submitted by the following people:

    i) prisoners, detainees, and young people, including those in youth detention accommodation,[42] who have failed to obtain satisfaction from the internal complaints system in place at the relevant institution;

    ii) offenders who are, or have been, under probation supervision, or accommodated in approved premises and who have failed to obtain satisfaction from the probation complaints system; and

    iii) immigration detainees,[43] including residents of immigration removal centres, pre-departure accommodation, short-term holding facilities and those under managed immigration escort anywhere in the UK,[44] who have failed to obtain satisfaction from the Home Office complaints system.

[42] For the purposes of complaints, this does not include secure children's home accommodation.

[43] Defined throughout as those detained under the powers of the Immigration Act powers.

[44] Complaints from individuals other than immigration detainees, as defined under the Immigration Act 1971 at the time of their complaint, will be investigated by the IPCC for England and Wales, the Police Investigations Review Commissioner in Scotland or the Police Ombudsman for Northern Ireland.

16. The Ombudsman will normally only act on the basis of eligible complaints from those individuals set out at paragraph 15 and not on those from other individuals or organisations. However, the Ombudsman has discretion to accept complaints from third parties on behalf of individuals set out at paragraph 15, where the individual concerned is either dead or is unable to act on their own behalf.

17. The Ombudsman also has discretion to accept complaint referrals (that it would be inappropriate for the authority to consider under its own internal complaints procedure) direct from HM Inspectorate of Prisons (HMIP) or the Independent Monitoring Boards (IMB), acting on behalf of the National Preventive Mechanism under OPCAT,[45] where a detainee alleges that the authority has prevented them from communicating with HMIP, the IMB or PPO, or that they have been subject to victimisation or sanctions as a result of doing so.[46]

Eligibility of Complaints

18. Before putting a complaint to the Ombudsman, a complainant must first seek redress through appropriate use of the relevant prison, youth detention accommodation,[47] probation, or Home Office complaint procedure.

19. Complainants will have confidential access to the Ombudsman and no attempt should be made to prevent a complainant from referring a complaint to the Ombudsman. The cost of postage of complaints to the Ombudsman by prisoners, immigration detainees and young people in detention, will be met by the relevant authority.

20. Where there is some doubt or dispute as to the eligibility of a complaint, the Ombudsman will contact the relevant authority in remit who will provide the Ombudsman with such documents or other information as the Ombudsman considers are relevant to considering eligibility.

21. If a complaint is considered ineligible, the Ombudsman will inform the complainant and explain the reasons, in writing.

[45] The Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) is an international human rights treaty designed to strengthen protection for people deprived of their liberty. It recognises that such people are particularly vulnerable and aims to prevent their ill-treatment through establishing a system of visits or inspections to all places of detention. OPCAT requires that States designate a 'national preventive mechanism' (NPM) to carry out visits to places of detention, to monitor the treatment of and conditions for detainees and to make recommendations regarding the prevention of ill-treatment. The UK ratified OPCAT in December 2003 and designed its NPM in March 2009. The UK's NPM is currently made up of 18 visiting or inspecting bodies who visit places of detention such as prisons, police custody and immigration detention centres.

[46] The relationship between the named bodies is described in a separate protocol.

[47] For the purposes of complaints, this does not include secure children's home accommodation.

22. The Ombudsman may decide not to accept a complaint otherwise eligible for investigation, or to discontinue any ongoing investigation, where he considers that no worthwhile outcome can be achieved, or the complaint raises no substantial issue.

23. The Ombudsman may also decide to discontinue an investigation where he considers the complainant's behaviour to be unreasonable.[48] The Ombudsman will inform the complainant of the reasons for this action.

Time Limits

24. The Ombudsman will consider complaints for possible investigation if the complainant is dissatisfied with the reply from the authority in remit, or receives no final reply within six weeks of making the complaint (or 45 working days in the case of complaints relating to probation matters). Complaints relating solely to healthcare will be dealt with by the Parliamentary and Health Service Ombudsman.

25. Complainants submitting their case to the Ombudsman must do so within three calendar months of receiving a substantive reply from the relevant authority.

26. The Ombudsman will not normally accept complaints where there has been a delay of more than 12 months between the complainant becoming aware of the relevant facts and submitting their case to the Ombudsman, unless the delay has been the fault of the relevant authority and the Ombudsman considers that it is appropriate to do so.

27. Complaints submitted after these deadlines will not normally be considered. However, the Ombudsman has discretion to investigate those where it considers there to be good reason for the delay, or where it considers the issues raised to be of sufficient severity to warrant an exception to the usual timeframe to be made.

28. The Ombudsman's targets around conducting investigations, responding to complainants, and publishing reports will be set out in an annual business plan.

[48] As defined by the PPO policy on Dealing with Unreasonable Behaviour from Complainants.

Limitations on matters subject to investigation

29. The Ombudsman may not investigate complaints about:

    i) policy decisions taken by a Minister and the official advice to Ministers upon which such decisions are based;

    ii) the merits of decisions taken by Ministers, except in cases which have been approved by Ministers for consideration;

    iii) actions and decisions (including failures or refusals to act) in relation to matters which do not relate to the management, supervision, care and treatment of the individuals described in paragraph 15 or outside the responsibility of the authority in remit. This exclusion covers complaints about conviction, sentence, immigration status, reasons for immigration detention or the length of such detention, and the decisions and recommendations of the judiciary, the police, the Crown Prosecution Service, and the Parole Board and its Secretariat;

    iv) matters that are currently or have previously been the subject of civil litigation or criminal proceedings; and

    v) the clinical judgement of medical professionals.

Fatal Incidents

30. The Ombudsman's fatal incident investigations will support the UK's compliance with the requirements of Article 2 (read with Article 1) of the European Convention on Human Rights which ensures the right to life, specifically the need for the independent investigation of all deaths in custody.

31. The Ombudsman will investigate the circumstances of the deaths of:

    i. prisoners and young people including those in youth detention accommodation[49] and those placed in Secure Children's Homes on a welfare basis. This generally includes people temporarily absent from the establishment but still subject to detention (for example, under escort, at court or in hospital). It generally excludes people who have been permanently released from custody, including those who have been released on compassionate grounds;

    ii. residents of approved premises (including voluntary residents) where the PPO considers this is necessary, including for Article 2 compliance;

[49] This covers deaths in young offender institutions, secure training centres and secure children's homes.

iii. immigration detainees, including residents of immigration removal centres, pre-departure accommodation, short-term holding facilities and those under managed immigration escort anywhere in the UK and internationally;[50] and

iv. people in court premises or accommodation who have been sentenced to or remanded in custody.

32. The Ombudsman will act on notification of a death from the relevant authority and will decide on the extent of the investigation, which will be determined by the circumstances of the death.

33. The aims of the Ombudsman's investigations are to:

- establish the circumstances and events surrounding the death, in particular the management of the individual by the relevant authority or authorities within remit, but also including any relevant external factors;
- examine whether any change in operational methods, policy, practice or management arrangements would help prevent a recurrence;
- in conjunction with NHS England[51] or the relevant authority,[52] where appropriate, examine relevant health issues and assess clinical care;
- provide explanations and insight for the bereaved relatives; and
- help fulfil the investigative obligation arising under Article 2 of the European Convention on Human Rights ('the right to life') by working together with coroners to ensure as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable action or practice is identified, and any lessons from the death are made clear.[53]

[50] The deaths of individuals other than immigration detainees, as defined under Immigration Act powers at the time of death, will be investigated by the IPCC for England and Wales, the Police Investigations & Review Commissioner in Scotland or the Police Ombudsman for Northern Ireland.

[51] The NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations confer responsibility on the NHS Commissioning Board (NHS England) for commissioning health services in prisons and custodial establishments.

[52] In the case of fatal incidents in Immigration Removal centres in Scotland or Northern Ireland.

[53] The relationship between the Ombudsman and the Coroners' Society is described in a separate Memorandum of Understanding.

Clinical issues

34. The Ombudsman's investigation includes examining the clinical issues relevant to each death. In the case of deaths in prisons, youth detention accommodation, Secure Children's Homes and immigration facilities, the Ombudsman will ask NHS England or, in Wales, the Healthcare Inspectorate Wales (HIW)[54] to review the clinical care provided according to agreed protocols, including whether referrals to secondary healthcare were made appropriately. The clinical reviewer will be independent of the relevant authority's healthcare provision and will have unfettered access to healthcare information. Where appropriate, the reviewer will conduct joint interviews with the Ombudsman's investigator.

Relationship with other investigations

35. The Ombudsman may defer all or part of an investigation, when the police are conducting a criminal investigation in parallel. If at any time the Ombudsman forms the view that a criminal investigation should be undertaken, the Ombudsman will alert the police.[55]

36. In the case of the death of a young person in custody, the Local Safeguarding Children Board in England will conduct a serious case review. In Wales, the Safeguarding Children Board may undertake a child practice review. This will normally take place in parallel to the Ombudsman's investigation. The PPO will seek to work closely with the relevant Safeguarding Board to maximise the benefit of both exercises.

37. If at any time the Ombudsman forms the view that a relevant authority in remit should undertake a disciplinary investigation, the Ombudsman will alert that authority. If at any time findings emerge from the Ombudsman's investigation that the Ombudsman considers require immediate action by the relevant authority, the Ombudsman will alert the relevant authority to those findings.

[54] In the case of fatal incidents in Immigration Removal centres in Scotland or Northern Ireland, the equivalent relevant authority.

[55] The relationship between the Police and the Ombudsman is described in a Memorandum of Understanding between the ACPO/APA and the PPO.

Outcome of the Ombudsman's investigations

38. The Ombudsman has the discretion to choose the exact manner in which the findings of investigations are reported but all investigations will result in a written response. The targets will be set out in the Ombudsman's annual business plan.

39. Where a formal report is to be issued the Ombudsman will send a draft and any related documents to:

    - the head of the authority in remit and the complainant in the case of a complaint. The Ombudsman may, however, share an advance draft with the authority where there is a concern over the disclosure of security issues; and
    - the head of the authority in remit, and the bereaved family, the Coroner, NHS England or HIW[56] in the case of a fatal incident report.

40. The recipient(s) will have an agreed period to draw attention to any factual inaccuracies. The relevant authority may also use this opportunity to respond to any recommendations.

41. If the draft report recommends disciplinary action be taken against an identified member of staff, the Ombudsman will normally disclose an advance copy of the draft, in whole or part, to the relevant authority in order that they, and the staff member(s) subject to criticism, have the opportunity to make representations (unless that requirement has been discharged by other means during the course of the investigation).

42. The Ombudsman will consider any feedback on the draft report, but will exercise his own discretion on what, if any, changes to make, and issue a final report. Final reports into complaints will be issued to the complainant and the relevant authority. Final reports into fatal incidents will be issued to the relevant authority, the bereaved family, the Coroner, the Local Authority, NHS England or HIW[57]. Additional circulation of final reports will be at the Ombudsman's discretion.

43. In the case of a fatal incident investigation, and having considered any views of the recipients of the report, and having complied with the legal obligations in relation to data protection and privacy, the Ombudsman will publish the final report on the Ombudsman's website. All references to individuals other than the deceased will be anonymised.[58]

[56] In the case of fatal incidents in Immigration Removal centres in Scotland or Northern Ireland, the equivalent relevant authority.

[57] In the case of fatal incidents in Immigration Removal centres in Scotland or Northern Ireland, the equivalent relevant authority.

[58] In reports of fatal incident investigations of people under the age of 18, the deceased person's details are also anonymised.

44. The Ombudsman will consult the Coroner or relevant authority if the report is to be published before the inquest.

45. The Ombudsman may make recommendations to the authorities within remit, the Secretary of State for Justice, the Home Secretary, the Secretary of State for Education, the Secretary of State for Health or to any other body or individual that the Ombudsman considers appropriate given their role, duties and powers.

46. The authorities within remit, the Secretary of State for Justice, the Home Secretary, the Secretary of State for Education or the Secretary of State for Health will provide the Ombudsman with a response within four weeks indicating whether a recommendation is accepted or not (in which case reasons will be provided) and the steps to be taken by that authority within set timeframes to address the Ombudsman's recommendations. Where that response has not been included in the Ombudsman's report, the Ombudsman may, after consulting the authority as to its suitability, append it to the report at any stage. The Ombudsman will advise the complainant of the response to the recommendations.

Disclosure

47. The Ombudsman is subject to the Data Protection Act 1998 and the Freedom of Information Act 2000.

48. In accordance with the practice applying across government departments, the Ombudsman will follow the Government's policy that official information should be made available unless it is clearly not in the public interest to do so.

49. The Ombudsman, HM Inspectorates of Prisons and Probation, and the Independent Monitoring Boards will share relevant information, knowledge and expertise, especially in relation to conditions for prisoners, residents and detainees generally. The Ombudsman may also share information with other relevant specialist advisers, such as the Independent Police Complaints Commission, and investigating bodies, to the extent necessary to fulfil the aims of an investigation. Protocols will be developed in order to describe the Ombudsman's relationship with relevant partners.

Staff list

Ombudsman
Nigel Newcomen CBE

Deputy Ombudsmen
Kimberley Bingham
Michael Loughlin (left 31 July 2016)
Elizabeth Moody
Richard Pickering (started 1 August 2016)

Assistant Ombudsmen
Lisa Burrell (started 13 March 2017)
Karen Cracknell (left 31 December 2016)
Michael Dunkley
Susannah Eagle
Kate Eves (on career break)
Karen Johnson
Wendy Martin (left 31 October 2016)
Caroline Mills
Neil Mullane (started 4 April 2016)
Louise Richards (started 6 March 2017)
Simon Stanley
Lee Quinn
Jane Willmott
Nick Woodhead

Policy Officer and Secretary to Executive Committee
Caroline Parkes
Rachael Biggs

Strategic Support Team
Durdana Ahmed
Ermelinda Bajrami
Catherine Costello (left 18 April 2016)
Dan Crockford
Rowena De Waas
Henry Lee
Esther Magaron
Tony Soroye
Ibrahim Suma

Learning Lessons Team
Olly Barnes
Tori Buttercase (started 1 August 2016)
Sue Gauge
Chauncey Glass (started 11 July 2016)
John Maggi
Adam Murton (seconded from 27 January 2017)
Christine Stuart (left 6 November 2016)
Vicky Tuck (started 7 November 2016)

Complaints Assessment Team
Nana Acquah
Susan Ager
Veronica Beccles
Agatha Eze
Alison Goby
Siobhan Green
Helena Hanson
John Howard (left 11 Nov 2016)
Leoni Larbi
Parvez Miah
Chris Nkwo
David Watson

Family Liaison Officers
Narinder Dale
Abbe Dixon
Laura Spargo (left 8 January 2017)

Senior Investigators and Investigators

Sharon Adonri
Amanda Anglish
Martha Archibald
Terry Ashley
Georgina Beesley (left 29 July 2016)
Rachael Biggs
Diane Blyth
Tracey Booker
Nicole Briggs
Simon Buckley
David Cameron
Shauna Carroll (started 10 October 2016)
Karen Chin
Althea Clarke-Ramsey
Debbie Clarkson
Akile Clinton (returned from career break 18 October 2016)
Vicki Cole
Paul Cotton
James Crean
Paul Crocker (started 31 October 2016)
Rob Del-Greco
Peter Dixon
Nick Doodney
Angie Dunn
Stephen Garbett (started 19 September 2016)
Juan Diego Garzon
Kevin Gilzean
Maria Gray
Christina Greer
Claudette Gyampoh (started 1 June 2016)
Rachel Gyford
Joanna Hurst
Lindsay Jones
Mark Judd
Razna Khatun
Madeleine Kuevi
Lisa Lambert
Karl Lane
Anne Lund
Steve Lusted
Steve McKenzie
Beverly McKenzie-Gayle (left 30 September 2016)
John McVeigh (left 22 July 2016)
Catriona MacIvor
Graham Manders (started 5 September 2016)
Sonja Marsh
Kirsty Masterton
Anita Mulinder
Tamara Nelson
Claire Parkin
Katherine Pellatt
James Peters (left 23 September 2016)
Jade Philippou (on career break)
Mark Price (left 31 March 2017)
James Raftery (started 24 October 2016)
Nicola Robinson
Rachel Rodrigues (career break from 15 June 2016)
Martina Ryan
Rebecca Sanders (left 16 March 2017)
Andrea Selch
Kai Sinor (left 19 August 2016)
Anna Siraut
Katherine Solomon
Sarah Stolworthy
Rick Sturgeon
Tina Sullivan
Jade Swietochowska
Paul Televantou (left 31 December 2016)
Daniel Thomas
Stephen Thompson
Jonathan Tickner (left 29 April 2016)
John Unwin
Charlotte Walton
Erica Webb (left 31 December 2016)
Alix Westwood
Karl Williamson

DESIGN102 | This document was designed by DESIGN102.
Contact us at design102@justice.gsi.gov.uk