This month's featured articles:

The Ombudsman's Opening

Welcome to the latest edition of The Investigator. Issue 10 has articles about both our complaints and fatal incident functions, and we hope they will give readers a taste of how wide ranging our work is, not just our investigations but the follow up work and thematic projects we do. You will see from the article on complaints handling that we continue to explore how we can build confidence in, and raise awareness of, our complaints investigations. In another article, we talk about our fatal incident investigation reports and how you can access them via our website.

Since the last issue of The Investigator in October 2021, we have published our updated Terms of Reference (ToRs). We have expanded our remit to include the deaths of babies in prison and to investigate more post-release deaths. You can read the revised ToRs on the PPO website here.

Once again, as we publish this issue, we are preparing to get back into our offices and to visit prisons, both in the course of our investigations and to do more of the engagement work which has been successful in the past. We are going to be talking to people in prison about our work, working with prison staff to improve the quality of responses to complaints and engaging more with governors and prison group directors to strengthen the impact of our reports. More to come on some of those projects in future issues.

Thank you for reading The Investigator; as always, we welcome your interest and are happy to have your feedback.

Sue McAllister CB

This month's featured articles:

Complaints handling in prisons

"Focus group responses showed there was a considerable lack of trust in the whole complaints process."

The Prisons and Probation Ombudsman (PPO) has set out to examine how prisoners experienced the complaints system (both the internal HMPPS and PPO stages of the process). As complaining to the PPO is the final stage of the complaints process for prisoners, we wanted to use this project to better understand the wider context of our work. An analysis of PPO complaints data also suggested that ethnic minority prisoners form a disproportionately large group of complainants to the PPO when compared with their prison population, and we wanted to explore why. We also wanted to understand prisoners' perceptions of the legitimacy, efficacy, and fairness of the complaints system (including both HMPPS and PPO stages).

To research this, the PPO included a survey in Inside Time (the national newspaper for prisoners) to get prisoners' views of the complaints process. The emerging findings from the survey were used to develop topics and questions for focus groups and interviews that we conducted in 2019. We randomly selected six prisons for the focus groups: two from the Long Term and High Security Estate and four from the adult male estate. Each focus group contained a mix of prisoners who had and had not submitted complaints to the PPO. Two focus groups were conducted at each prison and one group was made up exclusively of ethnic minority prisoners. At each prison, we also interviewed two members of staff with experience of handling complaints.

Experiences of the complaints process

Focus group participants were asked how well they understood the prison complaints process. A lot of participants knew about the process, but only a few of them said they had been told about it as part of their induction. Some of the participants who did not know about it were in prison for the first time and had recently arrived.

Many participants did not recall receiving information about the HMPPS or PPO complaints process at their induction. Some participants said they had not heard of the PPO before being invited to attend the focus group. Reasons for not complaining to the PPO included:

- Participants suspecting that the PPO was not impartial and would side with HMPPS
- Thinking that PPO investigations would take too long

- Not understanding how to make a complaint to the PPO, or not having access to the right forms
- Thinking that staff would read the complaint
- Not having the right contact details for the PPO.

Few participants remembered having seen PPO posters, and when we asked staff, many of them did not know whether these posters were displayed in the prison. Some of the staff said they did not signpost to the PPO when responding to an appeal and did not know how to do this.

Despite all this, some prisoners thought that contacting the PPO was an effective way to get results.

Focus group responses showed there was a considerable lack of trust in the whole complaints process. For some, this was about transparency: participants thought information was being withheld from them or that complaints about members of staff were not investigated properly. For others, it was about assurances that were not kept. Additionally, when prison staff were asked about responding to complaints, some said that the response letters used were never changed, no matter what the complaint.

In all the focus groups, participants said they thought it was harder for prisoners for whom English was not their first language to make a complaint (in both HMPPS and PPO complaint processes, complainants are encouraged to submit their complaint in writing). None of the staff interviewed could recall any prisoners asking to submit a complaint in a different language.

The research found inappropriate use of interim responses, such as staff not using an interim response even though the deadline for the complaint to have been substantively dealt with had passed, or over-using interim responses and failing to provide final responses to complaints. Prisoners also said that use of informal interim responses made it harder for them to keep track of their complaints. Many participants said they had never had responses to their complaints. Staff also acknowledged that complaints were not always answered.

Staff said that it could be difficult to direct complaints to the right department for a response. When asked in their interviews, operational staff thought that there should be a designated complaints respondent in the prison.

Some staff who responded to complaints said they would aim to speak to the complainant prior to providing a written response to better understand and resolve the complaint. Some said that they held regular surgeries and councils where prisoners could bring questions and concerns, with the aim of resolving issues before they reached the complaints stage. Some prisoners agreed that this happened, however, some complainants were mistrustful of this process.

Participants knew that, according to the prison policy in place at the time, there was a time frame for when they should receive a response to their complaint, but few said that they had received one in time. Some staff found time to speak to complainants

and submit responses. Others said there were too many demands on their time, and the wings were too short-staffed for them to set aside time to respond.

Some participants in the groups stated that they feared, or had experienced, repercussions because of making complaints (such as receiving IEP warnings, or that officers would make their lives more difficult). Sometimes this followed a more general expectation about how they would be treated in prison, or the experiences or perceptions of others that they had heard about. There was also the sense that the more complaints they made, the less seriously they would be taken. Staff were also aware of these views among the prisoners and stated they had done work to try to dispel the belief.

Experiences and perceptions of minority ethnic prisoners

In the focus groups made up exclusively of ethnic minority prisoners, some participants felt that staff did not understand the needs of ethnic minority prisoners and so would not handle their complaints appropriately.

When presented with a scenario in which racial discrimination was a potential issue, some participants stated it would be a waste of time submitting a complaint. A few then suggested that racism is too pervasive in the prison service to be able to act against it. Comments from staff indicated a lack of meaningful consideration of ethnicity.

One person described having made a complaint when a few black prisoners had been sacked from a certain job, and received a response saying that it did not concern him. It is unknown whether the prison would have taken any action about this. It is understandable, however, that the complainant may have felt affected and concerned by this as a black prisoner themselves and receiving a dismissive response.

The research from the minority ethnic focus groups did not identify big differences between complainants who were white and who were not. This shows that this research is but a starting point, and more should be done to further delve into this topic.

Conclusions

Despite negative views on the HMPPS and PPO complaints processes, our research showed that prisoners still complained, even if they did not expect a satisfactory outcome.

Overall, the focus groups showed there was a considerable lack of trust in the process. This is not surprising when there were issues with interim responses, and a lot of participants said they had never had responses to their complaints. Worryingly, this was also confirmed by staff. Improvements to sharing information about the internal complaints process must also happen, so prisoners can receive information about the internal complaints process, including dispelling worries and fears regarding repercussions from making complaints.

From this, HMPPS could establish some points that could be looked at: they should be unequivocal about the fact that prisoners should not suffer detriment because of complaining; interim responses should be used correctly; they should ensure complaint forms are available (including non-English ones) and be clear about the internal complaints process, including signposting to the PPO.

Since this research has taken place, the PPO has provided more information on how to complain to the Ombudsman and how to do so correctly. This has been through working with National Prison Radio and Inside Time to raise awareness of the PPO. The PPO also conduct a monthly complainant survey that allows those who complain to us to raise concerns and issues with the processes. Finally, the PPO are doing more to understand why some people in prison, notably women and young people, rarely complain to us and what we can do to give complainants more confidence in the PPO.

Author: Allena Reed, Research Officer

Common complaints we investigate and how we might resolve them

"Our recommendations can help those in custody and even lead to improvements in the prison."

In this issue of The Investigator, we wanted to highlight some of the more common complaints we investigate and how we might resolve them.

Property

The most common complaint we receive relates to lost, missing or damaged property – and these complaints make up about 30% of our workload each year.

We know that property issues can affect anyone in prison, and that they can be extremely upsetting and frustrating for those in custody. Property complaints can be complicated for us to investigate, particularly those involving multiple prisons and difficult to read or poorly completed property cards. Often, our role is to remind prison staff that there is a comprehensive HMPPS property policy which gives plenty of guidance on how to correctly manage and record prisoners' property. For example, we investigate cases where prison staff haven't completed a cell clearance certificate when a prisoner has moved cell and hasn't packed their own property. Cases where staff simply haven't followed procedures are relatively simple for us to investigate, but it's frustrating to find the same issues arising time after time.

If we uphold a property complaint – which means we agree with the person who made the complaint – we can make recommendations to the prison to set things right. Most importantly for the person who complained, we often ask the prison to pay compensation so that they can buy replacements. If the property in question is of personal or sentimental rather than monetary value, we can recommend that staff apologise to the complainant. If our investigation identifies more widespread problems, we might recommend that the prison governor checks staff are complying with the HMPPS policy, or that they introduce new processes to ensure property doesn't get lost or damaged.

Staff behaviour

A small, but important, number of our complaint investigations are about staff behaviour. Sometimes these complaints are about the quality of day to day relationships, but some relate to use of force incidents.

These complaints can be among the most difficult to investigate because it is often one person's word against another and so we rely heavily on CCTV or body worn video camera footage of the incident. We have been working closely with HMPPS to make sure that staff understand the importance of turning on their body worn video cameras

at the beginning of an incident, and making sure that the footage is kept safe in case we, or the police, need to investigate.

As you might expect, there's a detailed HMPPS policy on use of force (PSO 1600) which sets out when and how staff can use force against a prisoner and what must happen after a use of force incident. Part of our investigation might involve:

- looking for evidence that staff tried to calm the situation before using force based on the evidence available,
- considering whether the force used was reasonable and proportionate,
- looking at whether the prisoner was examined by healthcare staff soon afterwards,
- looking for evidence that staff completed a witness statement shortly after the incident.

If we find that staff did not comply with the policy, we make recommendations to ensure mistakes aren't repeated. If we have serious concerns about how staff have behaved, we can recommend that the governor carries out an investigation.

Work and pay

Sometimes we receive complaints from prisoners who think that they were unfairly dismissed from work or weren't paid properly. To investigate, we look at national policies, but also local policies that the prison has created. This means that policies can differ from prison to prison and we know that can be frustrating for the complainant. However, we will check that local policies comply with national policies. If we find that mistakes have been made, we recommend actions to put things right, for example ensuring the complainant is paid the correct amount, or that the local policy be changed.

We hope this article has given more information about some of the types of complaints we investigate and highlighted how our recommendations can help those in custody and even lead to improvements in the prison.

Author: Susannah Eagle, Complaints Deputy Ombudsman

Substance testing in Approved Premises

The PPO's Learning Lessons Bulletin, Approved Premises – Substance Misuse published in November 2017, highlighted the risks posed by psychoactive substances (PS) in Approved Premises (APs). The PPO has previously recommended that APs develop mechanisms to test for PS use, and since the bulletin's publication, the Approved Premises (Substance Testing) Bill has been brought forward and is currently in the final stages of reading. The Bill aims to provide a clear legislative regime for substance testing in APs, including for PS.

Historically, APs have not tested for PS, although the AP Manual states that if residents have a history of substance misuse, or if staff suspect them of misusing drugs, they should be tested for drugs and alcohol. The upcoming Bill and anticipated testing framework illustrate the importance of the recommendations made by the PPO. This article provides two further case studies, since the bulletin's publication, that reinforce why the upcoming Bill is needed and important.

Mr A was released on licence from prison to live at an AP. He had a history of substance misuse and before his release from prison, he had started to take PS again. Five days after his arrival, his roommate reported that Mr A was using crack cocaine and PS. Probation staff reacted appropriately by searching Mr A's room and by testing him for drugs, which showed no evidence that he had used illicit substances. However, they did not test him for PS use. Mr A's room mate stated that there was a drugs culture at the AP, with residents taking drugs in their room or in the garden. Reports over the next 10 days indicated that Mr A was regularly using PS. One of the residential support supervisors smelt what she thought was PS on the night that Mr A died but did not challenge him about it.

Before he died, Mr A went to the kitchen and asked an officer for food and milk. Although the officer thought Mr A might have taken an illicit substance, due to his appearance and gestures, he took no further action and sent him to his room. In the morning, his roommate found him dead on the floor, with the bed throw over his head. He had died from cocaine and PS toxicity. The PPO recommended that the National Probation Service should ensure that staff monitor residents appropriately when they suspect that they have used illicit substances and that they seek medical assistance, when needed. The PPO also recommended that the AP team should review its strategy to reduce the supply and demand for PS in Approved Premises, including developing mechanisms to test for PS use, which have since been developed.

Mr B was released from prison on licence to live at an AP. He had a history of drug and alcohol abuse, most notably 'monkey dust', a PS that distorts reality and results in the user not being able to recollect their actions while under the influence. As part of a drug reduction programme, Mr B received a regular prescription of subutex, a heroin substitute and engaged with One Recovery, an independent agency which managed his drug treatment. During his time at the AP, Mr B provided positive test results on different occasions for cocaine, cannabis, and benzodiazepines as well as disclosing use of 'mamba' (a type of PS). After Mr B had completed his heroin

substitute programme, he tried to take his own life, which he stated was due to him having problems in obtaining subutex. AP staff put in place a Care Action Plan. In the following two months, Mr B told staff that he had used PS. He was also given a formal warning after testing positive for benzodiazepine and cannabis.

Over the following weeks, staff raised no further concerns as he gave no indication that he was under the influence of illicit substances (although he was not tested for PS) or that he had suicidal thoughts. On the day of his death, Mr B and three other residents went to an area frequently used by drug users and drank alcohol. He was later found dead, suspended from a tree with a ligature around his neck. Although no post-mortem toxicology tests were completed, the PPO considered it possible, if not likely, that drugs played a significant role in his decision to take his own life. In the period before his death, there was little to indicate that Mr B was at a heightened or imminent risk to himself. The PPO recommended that the National Probation Service should review its strategy to reduce PS in APs and develop mechanisms to test for PS use.

In conclusion, the two case studies highlight two individual instances of why testing for PS use in APs is important and emphasise the potential direct effect testing can have on residents. The upcoming Bill is important in not only providing a legislative framework for testing in APs, which will directly affect PS use, but also combatting any potential drugs cultures in APs, which may continue to exist if such frameworks are not put into place.

Author: Alessia D'Aqui

Fatal Incident investigation reports

As well as investigating complaints from those in custody, the PPO carries out independent investigations into the deaths of prisoners or detained individuals in:

- Prisons
- Young Offenders Institutions and Secure Training Centres
- Secure Children's Homes
- Immigration Removal Centres
- Probation Approved Premises
- The custody of Prisoner Escort and Custody Service (PECS) in court premises or on escort

The Ombudsman can also investigate the death of someone who has recently been released from custody at their discretion.

If a death is within our **remit**, an investigator will lead the investigation and a PPO family liaison officer will liaise with the bereaved family. The investigator will gather evidence about the individual's time in custody, and the circumstances leading up to their death and immediately afterwards. This includes examining all the relevant records and policies, together with interviewing staff and prisoners or residents, if required. We also work with NHS England, who commission (where necessary) an independent clinical review of the health care provided while in custody to the person before their death.

After the investigation is complete, we will produce an initial report outlining the findings of the investigation and this will be shared with the next of kin and the establishment to check its accuracy. After we have considered any comments, we will produce a final report which is shared again with the next of kin and the establishment, but also the Coroner who conducts the inquest to establish how the person died.

Our reports often contain recommendations which aim to improve the quality of care given by the establishment and they can focus on what could be done to prevent similar situations happening in the future. The service in remit must tell us whether they accept our recommendations and let us know when they will implement them. The response to our recommendations are shared as actions plans on our website, along with the report.

It is important to note that the PPO will only publish a report on our website once the inquest has concluded: https://www.ppo.gov.uk/document/fii-report/. The FII reports page is a searchable record of our final reports which are published once they have been shared with next of kin and the coroner's inquest has taken place. Reports are sometimes uploaded to our website many years after a person's death, and this is because there are sometimes delays to an inquest being concluded or we may have to pause our investigation, for example due to a police investigation.

Please check the PPO website for reports before contacting us. You can use the filters to limit the display to specific case types, and the sort buttons to reorder by date of death or date the report was uploaded to the website. If you would like an update on a report that you cannot find on the website, please email: ppocomms@ppo.gov.uk

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