Prisons and Probation Ombudsman
for England and Wales

Annual Report 2007–2008

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by the Lord Chancellor and Secretary of State for Justice
by Command of Her Majesty
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CONTENTS

REFRESHING OUR RELATIONSHIPS

Just before this Annual Report went to the printers, the Criminal Justice and Immigration Act 2008 received Royal Assent. Had all gone according to plan, the Act would have re-established the Prisons and Probation Ombudsman as HM Commissioner for Offender Management and Prisons. In other words, it would have given effect to this office's long-standing ambition to become a statutory body.

Indeed, in its original iteration that completed all its stages in the House of Commons, the then Criminal Justice and Immigration Bill went much further than this. It afforded the Commissioner powers equivalent to those of the High Court to summon and examine witnesses and to ensure the production of documents. And it placed new responsibilities in respect of the conduct of joint investigations and the sharing of information.

Sadly, none of this came to pass. When the Bill had its second reading in the House of Lords, the Minister, Lord Hunt of Kings Heath, announced that the relevant clauses were to be withdrawn. It may be useful to quote his words in full:

"In placing what have previously been purely administrative arrangements on a firm statutory basis, it is the Government's view that the Bill would substantially enhance the standing and experience of the new commissioners. However, it is evident from public statements made by the current Ombudsmen [myself and my colleague, the Prisoner Ombudsman for Northern Ireland] and by the Parliamentary Ombudsman that there is significant concern about the provisions. All three Ombudsmen have argued for a different model that provides for direct accountability to Parliament … we wish to proceed … on the basis of a consensus if at all possible … I want to assure the House that the Government remain committed to placing these two important offices on a firm statutory basis. We will now enter into a period of further consultation with interested parties. We will need to be satisfied that any alternative statutory model will provide value for money and enhanced service. We hope that there will be an early opportunity for Parliament to return to this issue."[1]

There is no point pretending that the decision to withdraw the legislation was other than a deep disappointment to me personally and to the Prisons and Probation Ombudsman (PPO) office as a whole. Last year in this Annual Report I emphasised the centrality of independence to any Ombudsman's authority and bemoaned the petty restrictions on management action that followed from location within the Ministry of Justice/Home Office. Once the Bill

[1]House of Lords *Hansard*, 22 January 2008, cc 128–129.

was published, I believed it could sensibly be amended to reflect my concerns that it did not afford proper independence.[2] I had no expectation that it would simply not proceed.

Be that as it may, we will be working hard with colleagues to ensure that a principled and practicable consensus can be achieved and that there will indeed be an 'early opportunity' for Parliament to reconsider the matter. A reporting line to Parliament remains the best option for a pure Ombudsman body. But other options should be considered. Our sister organisation, the Independent Police Complaints Commission, is a non-departmental public body (NDPB). Such a model could well ensure both conspicuous independence from the Ministry of Justice and Home Office and greater day-to-day autonomy in the conduct of our business. Those outcomes would deliver the value for money and enhanced service that is the Government's – and this office's – objective. Such a model would also ensure that our investigations are fully compliant with the requirements of Article 2 of the European Convention on Human Rights.

> "We will be working hard with colleagues to ensure that a principled and practicable consensus can be achieved."

I wish to use this year's foreword to the Annual Report to talk about our links with other organisations (what in jejune management jargon are referred to as stakeholder relationships), both in the year that has passed and looking ahead to what I hope will not be long delayed: the new statutory office of HM Commissioner. Before doing so, I must offer some pointers on our activities and achievements during 2007–08.

On the complaints side of the office, it was a year of relative stability in terms of workload and decision-making. The number of complaints coming in rose by just over 1 per cent: a total of 4,750 complaints were received (4,231 prison complaints, 426 probation complaints and 93 immigration complaints) compared with 4,666 in 2006–07. The eligibility rate (in other words, the proportion of complaints received that met our terms of reference) was 34 per cent (again in line with a year earlier), and 1,673 complaints were investigated (up by 94 from 2006–07).

Among prison complaints, I would like to draw special attention to those relating to appeals against decisions not to grant early release subject to Home Detention Curfew (HDC). There is a very careful balance to be drawn in such decisions – HDC is controversial and must be subject to individualised risk assessment. On the other hand, with the prison population overflowing into police cells under Operation Safeguard (an odd name, one might think), it is critical that prison places are not clogged up with petty offenders who

[2] *Proceedings of the Public Bill Committee: Criminal Justice and Immigration Bill*, 18 October 2007.

could be safely released on electronic monitoring. Later in this report, I give examples of where this office has encouraged the National Offender Management Service (NOMS) and the Prison Service to make more sensible and proportionate decisions about risk.

Probation complaints continue to focus on the content of reports or on breakdowns in the relationship between the person being supervised and his or her probation officer (offender manager). My approach to the former is to vest in the report-writer a great deal of discretion as regards their interpretation of the facts. So far as the latter is concerned, I take it as a given that an offender cannot choose whom they are supervised by, any more than we can choose our bosses or our neighbours. However, I do not think it is in the interests of successful resettlement or public protection for an offender to be supervised by a particular probation officer if it is clear that the relationship has collapsed. It is good professionalism, not an admission of weakness, to make changes in the supervision arrangements in such circumstances.

From a domestic point of view, perhaps the most interesting complaints work has been that emerging from the Immigration Removal Centres (IRCs). We became responsible for immigration complaints in October 2006, so 2007–08 is the first full year on which I can report. I have included some examples of immigration complaints later in the Report. Here I should simply record that no unexpected patterns have emerged: just as in prisons, complaints about loss or damage to property represent the largest single category.

It is pleasing that complaints have come from each of the IRCs, an indication that awareness of this office has been achieved throughout the system. Nevertheless, I would like to do more by way of publicity and promotion, although this is critically dependent upon resources. I do not wish to over-emphasise this particular matter, but the performance of the PPO team – and our ability to take a more proactive role – is circumscribed by our budgetary position. We are the poor relations of virtually any other organisation with whom we could sensibly be compared.

On the fatal incidents side of our work, I must begin with the depressing statistic that the number of apparently self-inflicted deaths in prison rose from 73 in 2006–07 to 83 in 2007–08, an increase of 14 per cent. The total number of deaths where investigations were opened (that is, deaths from all causes and from all services in remit) grew by 19 (10 per cent) from 186 to 204. Given the pressures on the PPO office, I have deliberately limited the number of discretionary, post-release deaths that I take on. So many of them are drug related and, although each is mourned, is premature and is avoidable, the lessons very largely speak for themselves.

The overall number of self-inflicted deaths in prison was a great disappointment coming as it did after several years in which the trend was downward. However, I must caution against over-interpretation of a single year's figures. Both statistical theory and common sense tell us that any series of numbers will include random variations. That said, common sense also tells us that there are real reasons why prisoners are more at risk at a time of excess population, and why particular sub-sets of the prison population may be increasingly at jeopardy.

In that last category, the increase in the number of apparent suicides by foreign national prisoners has occasioned great concern in my office and more generally. In our investigations into these deaths, we have tended to find factors common to the deaths of all prisoners – British and foreign alike. There has been little to suggest that nationality or immigration status has been a determining characteristic, although it may have been an exacerbating one. It is manifest that the immigration removal system has become more robust and more certain, and public discourse about foreign national prisoners has been hostile. (Having said that, it should also be acknowledged that there has been no self-inflicted death in an IRC since January 2006.)

A tougher approach to lawbreakers may also be significant in respect to another group of prisoners who have taken their lives – those serving life sentences (or imprisonment for public protection (IPP)) or recalled from life licence. I am also concerned about those who have taken their own lives when well into long determinate sentences. The overall numbers are still small and I am not sure if they are statistically significant. However, it is no longer exceptional to learn of self-inflicted deaths in the training prisons, including the category C estate. In previous Annual Reports, I have drawn attention to the special riskiness of segregation and to those undergoing detoxification while in their first days in custody. Here I want to emphasise that the prevention of suicide and self-harm is absolutely not just a matter for overcrowded local prisons (indeed, overcrowding may be an irrelevance although 'churn' is not). In the words of a famous report by a former Chief Inspector of Prisons, suicide is everyone's concern.

The difference between a death in custody and a successful resuscitation may literally be no more than a matter of seconds. (In consequence of my office's investigations, all front-line staff now carry cut down knives.) And I have used this Annual Report on previous occasions to pay tribute to those many Prison Service staff who have saved lives by their rapid and professional intervention. It is also self-evident that as many or more lessons can be learned from a situation when a life is saved as from one where a life is lost.

At the time of writing, the law is in a state of flux in respect of the circumstances in which an attempted suicide (or other cases of near death) in custody may give rise to the investigative obligation arising from Article 2 of the European Convention on Human Rights. It may well not be until 2009 before a final view emerges from the House of Lords. However, this office stands ready to take on the additional responsibility for near death investigations should Ministers so decide. (The synergies between fatal incident and near death investigations are very close and the two responsibilities would sit well together.) All we ask is to be allowed proper time to recruit and train the necessary additional staff. In 2004, we took on the death in custody function with a lead time of just 13 weeks. The consequences of that haste continue to this day. We do not want to repeat the experience.

In the meantime, I have personally chaired the first Article 2-compliant investigation into a near death in this country in the case of D.[3] Indeed, for all I know this may have been the first such investigation anywhere in Europe. For that reason, it is of some public policy, legal and historical interest and I reflect upon some of the lessons elsewhere in this Report.

In January 2008, I commenced a second Article 2-compliant investigation (into the case of SP, a repeat self-harmer).

These special investigations have been a feature of the PPO office for some years. (This year, for example, I also conducted a review on behalf of the Minister of State into the way in which certain provisions of the Offender Management Act were introduced and their impact on prisoners.) However, I would be wrong to pretend that they have not placed some strain upon mainstream business. During the course of the year, I determined that the pressures on managers and investigators could no longer be sustained and established a third position of Deputy Ombudsman to cover central services, and appointed additional investigators. Conscious as I am of the budgetary restrictions facing many parts of the new Ministry of Justice, I am very grateful for the understanding shown towards my office.

The establishment of a third Deputy Ombudsman to head the strengthened Business Development and Central Services function has already paid dividends. Not least it has helped strengthen the office's senior management (although I believe that our grading structure is urgently in need of review). However, I am also conscious of how badly we have been affected by the long-term serious illness of some colleagues. It is very difficult for the office to cope with workload and other pressures when there have been continuing changes to the management team.

[3] Full details on my website (www.ppo.gov.uk) and from p. 50.

Nor can these pressures be magicked away. Take accommodation as a further example. Our space-occupancy is much tighter than in either the Ministry of Justice or Home Office, meeting and storage space is at a premium, and the essential services are under stress. Unless room can be found in Ashley House into which we can expand, we will need to relocate as a matter of urgency.

Whether that is with others or alone remains to be seen. Which brings me back to the theme of this foreword, our relationships with other organisations and individuals, both now and in the future.

I am very proud of the supportive, mutually respectful relationship that the PPO office enjoys with each of the services in remit. The Immigration Service (and the IRCs themselves and the contractors who run them) have engaged very well with our new responsibility for complaints. Indeed, the Border and Immigration Agency (now the UK Border Agency) has funded additional posts in the PPO office to enable us to carry out our investigative function properly. I may say in passing that the (at most) two-tier IRC complaints process works well and may have lessons for the three-tier system used in prisons and the three/four-tier system in probation.

The Probation Service has also engaged very constructively with us – less in respect of complaints, where we have made few recommendations, and much more in respect of fatal incidents, where we have made many. Approved Premises (probation hostels in more familiar parlance) are at the forefront of public protection, and I know that some of our recommendations have proved challenging. The degree to which they have been accepted and adopted has reflected well on probation as a whole.

However, there is no doubt that our closest relationship is with the Prison Service. It represents 85 per cent of the complaints work and well over 90 per cent of the fatal incidents. The support and interest throughout the Prison Service – from the officer on the wing to the Director General himself – has been critical to this office's success. I expect and intend that none of this should be put in jeopardy by future statutory authority. Indeed, I hope it will help strengthen the ties since our independence, role and powers will no longer be in any doubt.

We need to work harder with other stakeholders. The Department of Health has a close interest in our fatal incidents work, and this year conducted a most interesting analysis of our investigations into natural cause deaths in prison. However, a potential rubbing point concerns the clinical reviews that I am required to commission from the relevant primary care trust (PCT) under my non-statutory Terms of Reference. (The legislation was mute on the question of whether the NHS would continue to have the lead in respect of the

clinical aspects of deaths in custody investigations, but I imagine it would have done so.)

The Department of Health has issued new guidance to PCTs about those clinical reviews. It emphasises the need for independence, and for reviewers to have relevant expertise, and underlines the benefits of constituting a clinical panel. It also talks about joint interviews of clinical staff by the reviewer and the PPO investigator. All of this is very welcome. But I remain of the view that a better, more accountable, more Article 2-compliant approach would be if the PPO were funded to commission its own clinical reviews. The present system remains inconsistent and all too often is characterised by delays for which my office is unfairly blamed. Certainly many Coroners seem not fully to have grasped that it is frequently impossible for the PPO office to complete its report before the clinical review has been submitted.

As with the Department of Health, we must work more effectively with individual Coroners and with the Coroners Society. Of course, as independent judicial office-holders, individual Coroners are entitled to agree their own procedures so long as they are consistent with the Coroners Rules and Coronial law. (Like most observers, I regret the delay in bringing forward the Coroners Bill which would establish a new Chief Coroner to help spread good practice and common standards.) However, the results of this freedom of action are frequently confusing and frustrating for my office.

Sometimes my investigators are called to inquests; sometimes they are not. Sometimes they give evidence at the beginning; sometimes at the end. Sometimes they are asked solely about factual issues; sometimes solely about their conclusions. There are occasions when my investigators are expected to spend days on end listening to other evidence, before being called for 15 minutes in the witness box. There are other occasions when inquest juries have actually been prevented from seeing my reports. (I am not sure which of these latter practices is the more egregious: the first is a great drain on my office and waste of public money; the second seems to deny members of the jury information that could be critical to their determination.)

The Coroners Society and the Independent Police Complaints Commission have agreed a Memorandum of Understanding (MoU) to improve mutual understanding. We hope to develop our own MoU with the Coroners Society in the year ahead.

We already have such an MoU with the Association of Chief Police Officers and, in practice, it has worked very well. My office's fatal incident investigations would be much the weaker were the police not willing to share the statements they have taken and the documents they have

considered. Moreover, this close co-operation with the police means many witnesses do not have to be interviewed for a second time.

However, the current draft of the MoU cedes 'primacy' to the police, a concept that may not be entirely consistent with Article 2 compliance. Plainly, this office must do nothing that might imperil a police investigation or future prosecution. At the same time, we should expect to be able to get on with our own investigations whenever we can.

In our investigations into both fatal incidents and (albeit to a lesser extent) complaints, we are beginning to see a much greater involvement of lawyers in our work. There are many benefits, not least in ensuring that the views of complainants or of bereaved relatives are properly represented. But we also encounter a lack of understanding of the non-adversarial approach of an Ombudsman.

A non-adversarial investigation does not mean witnesses are not probed on the answers they give. We have a right to expect full and candid accounts of decisions, actions and inactions. Nor does it mean a cosy compromise between opposing viewpoints. However, it does mean treating witnesses respectfully and allowing them to tell their own story in their own words. And it also means trying to resolve a conflict in a manner with which all parties are comfortable; a restorative outcome rather than one with winners and losers. These represent the distinctive values and ways of working of all Ombudsmen.

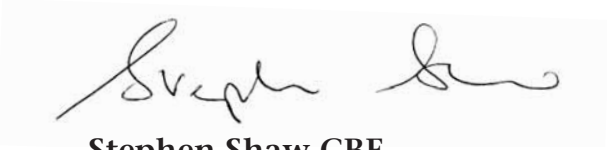
The PPO office has never accepted that it was somehow inferior to other Ombudsman institutions because of the absence of structural independence. However, we have been surprised and disappointed by the response towards the collapse of our legislation on the part of some in the wider Ombudsman movement. It would be far better if all Ombudsmen thought of themselves as part of a broad church rather than as members of an exclusive sect. After all, a flexible approach is also one of the distinctive values that Ombudsmen bring to bear.

Beyond all of these organised stakeholders, this office's most important relationship has always been with the individuals on behalf of whom our investigations are carried out. The relationship with the bereaved family is at the heart of our fatal incidents work. And the relationship with the complainant is necessarily at the heart of the complaints function.

I am conscious that we need to do more to strengthen these relationships – and would like us to do more outreach work in IRCs, in the Secure Training Centres (to whom the legislation would have extended the complaints remit) and Young Offender Institutions, and with other marginalised and hard-to-reach groups. We have made plans to that effect for 2008–09 and will need to carry them forward to future years as well.

Removing barriers to access is a further distinctive value of this and every other Ombudsman institution.

All that is for another time. I very much hope that a year or so from now I will finally be able to celebrate the office's new statutory identity. (If that is not forthcoming, then revision of my non-statutory Terms of Reference, and a review of our relationship with the Ministry of Justice, will become even more pressing.) All that remains this year is for me to thank my colleagues for the commitment and achievements that are represented in the body of this Annual Report.



Stephen Shaw CBE
Prisons and Probation Ombudsman for England and Wales

INVESTIGATING COMPLAINTS

Last year I reported on the effect that the growth in the prison population was having upon prisoners and staff alike. I also wrote about a culture of 'risk aversion' in respect of much decision-making, and the degree to which prisoners' lives had become more tightly regulated. Throughout this year the prison estate has continued to operate at almost maximum capacity.

The pressures on space have been felt in a number of ways, impacting upon cell sharing, transfer requests, regime delivery, sentence planning and risk assessments. As a keen reader of Independent Monitoring Board (IMB) reports, I know how many have drawn attention to the number of prisoners serving indeterminate sentences who are unable to progress through the system. And to those prisoners with severe mental illnesses who continue to languish in segregation units. Given this picture, it is not surprising if I sense that the prison population has become more fractious as a consequence.

Certainly, all of these factors are reflected in the prison complaints I receive. Property complaints and appeals against disciplinary adjudications have traditionally been the bread and butter of my office's complaints work, but these are beginning to be matched by complaints about regimes, about allocation and categorisation, and about risk assessment.

But despite the pressures, the so-called 'decency agenda' continues to inspire the best staff – in prisons, probation and immigration detention. I continue to be heartened by the instances of genuinely good practice that I encounter within the services in remit, and by the compassion and care shown to those in their charge who are vulnerable or disadvantaged.

I have chosen case studies to reflect the dilemmas that are faced daily by prison, probation and immigration staff. In other words, the balance between the rights and needs of offenders and detainees, and the rights and needs of the public to good order and protection from fear and harm. This is the same moral challenge that is at the heart of my office's own work. Indeed, this is what distinguishes it from any other Ombudsman's office and provides its endless fascination and worth.

Respect

The measure of a decent society is how it treats those at its margins, not least those who have broken its laws and lost their liberty. Consequently, complaints concerning issues of human dignity and decency are a particular concern of my office. Being sent to prison is itself a humbling experience for many, and prisoners experience what I have termed the 'necessary cruelties' of prison life – from strip searches to monitored telephone calls. The approach to complaints on these matters is to ensure that the actions of staff never go beyond what is necessary to maintain a secure and well ordered penal system.

Mr A complained about the condition of the in-cell lavatories. He said there was no lid to the lavatory seat and that the general condition and cleanliness of the toilets was poor. He considered it unacceptable that he had to eat his meals in such unhygienic conditions.

The prison in question had experienced problems with vandalism of the lavatory seats and was undertaking work to replace broken ones. Additionally, due to problems with the connection to the main sewerage system, chemical content in the outflow had damaged the treatment plant. As a result, the prison had to be careful about the chemicals used to clean the lavatories given the numbers connected to the system. However, it had failed to identify a suitable cleaning agent.

> "Prisoners experience the necessary cruelties of prison life – from strip searches to monitored telephone calls."

I accepted that the local Works Department was identifying and repairing damaged seats, but it was not acceptable

that prisoners were being held in unhygienic conditions. I upheld Mr A's complaint. I noted that criticism had previously been made of the standards of the in-cell sanitation by HM Chief Inspector of Prisons. I therefore drew the matter to the attention of the Area Manager so that a solution to the underlying problems could be identified and implemented as soon as possible.

Mr B, Mr C and **Mr D** all complained about the breakdown of the night sanitation door release system on their wing. They claimed 'institutional neglect' for being without toilet facilities or water access for five days.

Overcrowded and worn-out prison buildings are not conducive to easy maintenance of dignity, especially where it is physically impossible to fit toilet facilities in cells. One method the Prison Service has found to tackle this has been to fit electronic door release mechanisms so prisoners can be let out during lock-up times to use the toilet. One prisoner at a time is unlocked and allowed a maximum of nine minutes to return to his cell. Perhaps surprisingly, my office has not received many complaints on this. Until, that is, the system breaks down.

The authorities at the prison in question said that each prisoner had a bucket with lid, water bowl and jug for cleaning, and a flask of hot water for drinks. They also said they had believed the system would be repaired much sooner. My investigation revealed that the problem was electronic and that outside contractors had been called to undertake the repair. The hope was that the problem would be fixed within a day or two. However, this did not happen. The repair was apparently carried out quite quickly, but in order to get the system working again it required 're-booting'. The difficulty confronting the prison was that the problem was initially confined to one wing but there was a high probability that the 're-booting' process might cause the entire system to crash, leaving every prisoner in

the establishment without night toilet facilities.

One solution to the delay would have been to reallocate day staff to work at night unlocking prisoners to use the toilet. In practice, it took the prison five days to implement this measure and I judged that five days with no access to toilets at night was excessive. I therefore upheld the complaints and asked the Governor to ensure that, if a similar problem occurred, staff would be redeployed much more quickly.

Mr E complained that he had been unable to arrange an inter-prison visit between himself and a young man whom he believed to be his son who was being held in a Young Offender Institution (YOI). The visit could not take place because the YOI had no evidence of parentage. Mr E wanted a paternity test but had been advised that it was not the responsibility of the Prison Service to arrange this.

Enquiries by my office confirmed that it was not uncommon for healthcare staff to be asked to carry out paternity tests. However, the arrangements are generally made by the prisoner's legal representative who organises for the paternity test kit to be sent into the prison and sets up the pre- and post-test counselling. The prison's role is limited to collecting the samples and sending them back to the solicitors who then forward them to the laboratory. Individual prisons are not responsible for funding such tests.

I was satisfied that an inter-prison visit to a juvenile was not appropriate where there were doubts about the relationship. I was also satisfied that it was for Mr E and his legal representatives to arrange for a paternity test to be carried out.

Mr F complained that his cell had been searched by dogs and that some religious items and his bedding had been defiled.

He suggested that the actions of staff amounted to bullying.

My investigation found that staff at the prison had not been carrying out searches using the standards set out in either the Prison Service's National Security Framework or its Prison Service Order (PSO 4550) on religion. The latter makes clear that care must be taken when dogs are used to search cells and that prisoners must be given the opportunity to bring out religious artefacts to be searched separately. It also says that if dog hair or saliva comes into contact with a prisoner's clothing or bedding he must be given the opportunity to change it. However, I found no evidence to support Mr F's claim that his Qur'an had been thrown on the floor or that the search amounted to bullying.

The prison responded very promptly to Mr F's concerns and, before my final report had been issued, had already introduced new searching procedures to prevent bedding from being defiled and to ensure that staff placed religious items out of reach using gloves. As a result, I found that no recommendation was required and was happy to commend the sensitive way Mr F's complaint had been handled.

Staying in touch

The experience of being sent to prison is, for many prisoners, one of isolation from family and friends. Contact from home is highly valued. However, communications to and from prisoners are necessarily subject to control and

risk assessment. Many prisoners find it hard to accept the scrutiny and restrictions on their letters, telephone calls and visits. There are numerous local and national policy provisions covering prisoner communications and it is no surprise that my office receives significant numbers of complaints in this area each year.

Mr G complained that he was required either to make his telephone calls in English or to pre-book his telephone calls if he wished to speak in a foreign language. He felt this was unfair because his parents did not speak English.

Prison Service Order 4400 says that high risk or exceptional risk category A prisoners must pre-book their telephone calls. However, this is not the case for standard risk category A prisoners such as Mr G. The restrictions placed on him appeared to be the result of a local policy decision based on the nature of his offence rather than his risk.

The investigator in this case discovered that the Head of Security at the prison concerned was to conduct a review of the local security strategy. We fed into that review by drawing attention to discrepancies between the local policy and national guidelines. When the review was concluded, the local policy was amended so that standard risk category A prisoners no longer needed to pre-book their telephone calls.

Mr H, who was subject to a restraining order that prevented him from contacting his former partner (his victim), complained that letters sent by her were being withheld. Notwithstanding that the correspondence had been initiated by the ex-partner, in light of Mr H's offending history and the existence of the restraining order, the prison had decided it was not appropriate for him to receive the letters. Mr H said the prison had no right to withhold them.

I could appreciate both points of view in this case. The prison might reasonably feel that allowing Mr H to receive letters from the victim of his offences could encourage him to breach the restraining order. The intention was to take account of the court's evident wishes in protecting the victim. On the other hand, I understood why Mr H felt he should be allowed to receive the correspondence as the restraining order did not prevent the victim contacting him. Furthermore, I could find nothing in Prison Service rules or guidance that gave the Governor the right to withhold the letters and, for this reason, I upheld Mr H's complaint.

I recommended that the prison contact the court to explain that the victim was writing to Mr H, and to seek advice as to whether they had the authority to withhold her letters in the light of the existing restraining order. If the court advised that the order did not preclude Mr H receiving the letters, they should be issued to him. I also recommended that the Public Protection Manual, which offers guidance on such matters to prison staff, be revised to cover circumstances where a victim contacts a prisoner who is subject to a restraining order.

Mr J complained that a home-made Easter card sent by his niece had not been issued to him. The prison had taken this action because Mr J was subject to child protection measures and contact between him and his niece had not been authorised.

Mr J argued that the prison had overstepped the guidance on safeguarding children. He said the card was unremarkable and had been sent

along with one from his sister, the child's mother. He did not believe that the rules were intended to prevent this type of correspondence.

We examined the Public Protection Manual (PPM) and concluded that the guidance was poorly worded. However, it was clear that any contact with a person under 18 and not a member of the prisoner's immediate family must be risk assessed and approved. A niece is not considered to be a member of the immediate family. Consequently, I was satisfied that the prison was entitled to consider withholding the card. Above all else, the interests and welfare of the child must be paramount.

Nevertheless, the PPM rightly emphasises the need for proportionality. I was concerned that the prison had imposed a blanket refusal to allow contact of any kind between Mr J and his niece – whereas a more proportionate response might have been to have risk assessed the nature of the contact. The risks involved in receiving a single, one-off greetings card might well be manageable. I recommended that a risk assessment be carried out to see if Mr J could keep the card. I also recommended that my report be copied to the NOMS Public Protection Unit so that they could consider revising the wording of the PPM.

Mr K complained about the way in which his mail was being treated by staff at his prison. His complaint was two-fold. First, he was being required to open and seal his legal correspondence in front of staff. Second, he had been instructed to put his name and prison number on the flap of non-legal mail before sealing it. Mr K felt he was then being targeted by staff who were delaying sending out or returning his correspondence for no good reason.

Prisoners have the right to correspond with their legal representatives, and some other organisations such as the Ombudsman's office, without such mail being opened or read. Although each prison has procedures in place for dealing with legally privileged mail, sometimes things go wrong. During this reporting year, I have investigated a number of complaints about privileged mail being opened unnecessarily or being dealt with improperly.

In Mr K's case, my investigator established that prisoners were expected to 'fan' their legal mail in

front of staff before it was sealed to confirm that it contained no illicit enclosure. The officer would then sign the back of the envelope. Without the officer's signature the letter would not be sent. We were advised that there had been problems in the past with letters being inappropriately accorded privileged status. In respect of non-legal post, prisoners were required to write their name and number on the inside of the envelope flap so that staff could identify those prisoners subject to special measures, such as those with child protection restrictions in place.

I found no evidence that Mr K's mail was subject to special scrutiny or that he was being targeted by staff. Rather, it seemed that delays had occurred when he had not complied with local policies. I did not consider the arrangements for posting out non-legal mail to be unreasonable and I did not uphold this aspect of Mr K's complaint. However, while I understood the prison's thinking in imposing the additional security measures in relation to legally privileged mail, I was not satisfied that they were proportionate to the perceived security risk and they exceeded the national guidance. Clearly, if there are concerns that an individual is abusing the privilege, action should be taken. However, in this instance, a blanket policy had been imposed. I recommended that the policy that legally privileged mail had to be checked and sealed in front of a member of staff should cease immediately and that Mr K should receive an apology.

Mr L complained that he was not granted escorted visits to see his housebound mother. She had suffered a stroke and was no longer in a position to visit him. However, when Mr L applied for escorted visits, he was advised that there was no such facility. The answer to his appeal suggested that this was to do with the stage Mr L was at in his life sentence.

My investigator made enquiries and confirmed that life sentence prisoners may apply for one-day escorted absences in accordance with the National Security Framework and Lifer Manual. As a result, we asked the prison to review its decision. Unfortunately, while the Governor was sympathetic, the distance between the prison and Mr L's mother's address made an escorted visit impractical. The Governor simply did not have the staffing resources to accommodate such a visit.

However, the prison was able to suggest that Mr L might apply for either a permanent transfer or a period of accumulated visits at a prison closer to his mother's home.

Although I upheld Mr L's complaint, I felt that I could not reasonably intervene any further. The Governor had responded sensitively but needed to consider the impact on the prison as a whole. The suggested solutions to Mr L's circumstances were not unreasonable in the circumstances.

Inside justice

The maintenance of good order in prison is essential. Prisoners and staff need to feel safe, and it is in the interests of both for regimes to run smoothly. Prisoners who break the rules should be punished, but guilt must be properly established and punishments must be fair. The Ombudsman's office is the appellate body for prisoners who believe they have been treated less than fairly during disciplinary adjudications.

Mr M was found guilty of possessing an unauthorised article: a mobile telephone and charger. He appealed against the finding but was told that all appeals should be lodged within six weeks and he was out of time. Mr M complained that he had appealed using the relevant form which stated that appeals should be made within three months.

My investigation found that a Prison Service Order that came into effect in January 2006 had changed the time limit for submitting appeals and a new form was in use. Nevertheless, it was clear that most prisoners (and indeed some prison staff) were unaware of the new arrangements. The use of old forms compounded the problem. Having two forms giving contradictory information about the time limits for appeals was a recipe for confusion. I upheld Mr M's complaint and recommended that his appeal should be considered. I also recommended that the misinformation contained in old forms should be amended as a matter of urgency.

Mr N appealed against his finding of guilt for refusing an order to go to work. He said he had not been asked if he wanted legal advice and had not been allowed to call a witness. Mr N also said he had not pleaded guilty and the adjudication had not been recorded accurately.

It has long been my practice to rely upon the record of hearing as accurately reflecting what happened and what was said. Unless there is some other reason to doubt the accuracy of the record, I do not see how I can do otherwise. In Mr N's case I was satisfied that, according to the record, the adjudicator had sufficient grounds to find the charge proved. However, this complaint was one of a number of cases in the past year where prisoners disputed the accuracy of records of hearings. It caused me to revisit a recommendation I made in 2002. This was that the Prison Service should conduct a review of the costs and benefits of introducing audio-recording of adjudications, and pilot such a scheme. (Audio-recording of

adjudications is already in place in the Northern Ireland Prison Service.)

Mr P complained that the finding of guilt for possession of a quantity of unauthorised CDs was unfair. In particular, he said he had asked to call two witnesses but the adjudicator refused his request without considering what evidence the witnesses might provide.

My investigation found that, although the hearing had been adjourned for the presence of the witnesses, they were not in fact heard at the reconvened hearing and the record did not say why Mr P's request had been refused. I felt this was a fatal flaw in the procedure as the Prison Discipline Manual makes clear that the adjudicator must note the reasons why a request for witnesses is refused. As I could not be satisfied that Mr P's request had been properly considered, I upheld his complaint and recommended that the finding of guilt should be quashed.

Order of the day

Mr R complained that a prison officer had made unfounded allegations that he had received pornographic DVDs in the post. He said these allegations had been repeated in two reports for the Parole Board. Mr R felt he had been a victim of racist bullying by the officer who had also lost and damaged Mr R's property.

One of my investigators contacted the prison and was initially advised that Mr R's complaints had been dismissed. Moreover, Mr R was a 'persistent litigant' and he was restricted to one complaint a week. There was said to be no record of any loss or damage to his property. Further enquiries by the investigator revealed that the alleged

pornographic DVDs were missing and their content had not been verified. The prison amended Mr R's Parole Board reports and, in the course of the investigation, issued him with a formal apology.

The officer about whom Mr R had complained was suspended pending a police investigation into other matters and could not be interviewed. However, an examination of Mr R's property cards did not reveal any loss or damage, and I did not uphold this part of his complaint.

No investigation appeared to have been carried out into Mr R's complaints of racist bullying. Furthermore, I considered that restricting Mr R to one complaint per week was an excessive response to a prisoner who was deemed as abusing the complaints system; one complaint a day is a more proportionate response. I upheld these aspects of Mr R's complaint.

Ms S complained that her prison was denying prisoners adequate exercise and time in the open air. She said that the problems had begun during the winter months but had persisted into the summer, and that exercise sessions were often cancelled or curtailed without good reason.

Enquiries revealed that, although the length of time prisoners spent outside was a key performance indicator that needed to be reported to the Head of Residence, records were not being maintained regularly. The prison suggested that, in order to improve record-keeping and allow proper monitoring of the time spent in the open air, the exercise times could be incorporated into the Duty Manager's daily report. (This report is seen by members of the Independent Monitoring Board each day. It would thus enable them to monitor the frequency of any cancelled or curtailed sessions and consider if the explanations were reasonable.)

I was satisfied that this was a sensible way forward. I understood the prison's view that staffing levels did not always allow supervision of prisoners both inside and out, and that the preferences of the majority of prisoners were paramount. However, I made it clear that I would be concerned if an individual's right to be outside for a sufficient period of time was being regularly overlooked because their wishes and habits did not conform to those of the majority.

Mr T complained that a mobile phone found in his possession had been destroyed. His girlfriend had been banned from visiting him for three months on suspicion of having smuggled it in.

Mr T argued that, although the prison had evidence that his girlfriend had purchased the mobile phone, it had no proof of how it had come into the prison. He said the action taken against his girlfriend was merely vindictive. The prison responded by saying that, if Mr T provided details of how the phone had entered the prison, the ban on his girlfriend would be reviewed. Until then, the ban would stand.

I was satisfied that the Prison Rules properly allow a Governor to ban someone from visiting a prison or prisoner if there is a risk to security or good order, or for the prevention, detection, investigation or prosecution of a crime. I was also satisfied that the ban on Mr T's girlfriend, being time-limited, was proportionate. What had happened to the phone was less clear. It appeared it might have been sent to the police at one point, but probably then returned to the prison. In any event, a member of staff suggested to my investigator that unauthorised items were routinely destroyed.

It seemed to me entirely right that the mobile phone was confiscated. However, a mistake had then been made in destroying it. Although smuggling a phone into prison is a criminal act, a mobile phone itself is not an illegal item. Furthermore, the prison was already satisfied that the phone actually belonged to Mr T's girlfriend. That said, I did not believe it was at all appropriate to offer Mr T's girlfriend compensation for the loss of her phone. Given that mobile phones are banned in prisons (the threat to security and the link to the drugs trade need no elucidation), it cannot be an acceptable use of public money to compensate someone for the loss

of an item deliberately and illegally smuggled into prison.

Progression

Movement through the prison system is important to all prisoners, but particularly for those serving indeterminate sentences who are unlikely to be released before they can demonstrate that their risk of re-offending has reduced. Poor behaviour, failure to complete courses and likelihood of absconding may all affect categorisation and the level of privileges that a prisoner can earn. Many of the complaints I have received during the year have reflected the importance to prisoners of making progress.

Mr V was serving a six-year sentence and had spent the first 14 months as a category C prisoner. He said he had never had an adjudication, and had an excellent wing report. Despite this, Mr V complained that he was suddenly downgraded to category B and transferred as he was considered to be a security risk.

At the time of his sentence, Mr V had been made a category C prisoner. An assessment form completed a year later indicated there had been no risk change and described Mr V as polite and helpful. However, a further assessment completed two months later suggested information had come to light indicating higher risk factors.

Prison Service guidelines require that prisoners should only be downgraded because of a significant change in risk or behaviour, and the decision to downgrade Mr V conflicted with the evidence that there were no reported security concerns. My investigator brought this to the attention of Mr V's new prison who agreed to undertake a fresh assessment and reconsider his categorisation. It was subsequently agreed that he should be recategorised back to category C and a transfer was arranged to a category C prison.

Mr W was sentenced to an extended sentence under the provisions of the Criminal Justice Act 2003. He was required to serve 20 months in custody and 34 months on licence. He was sentenced to a further 12 months to run consecutively. He complained that, as he had been refused parole, the 12-month sentence should commence after he had served two-thirds of the extended sentence.

My investigator carefully examined the Prison Service Order on sentence calculation and sought guidance from officials. We confirmed that anyone given an extended sentence under the 2003 Act was eligible for parole at the half way point of the custodial period – but if it was refused they would not be released until the end of the custodial part of the sentence. I was satisfied that the principles by which Mr W's sentence had been calculated were correct and I could not uphold his complaint.

Mr Y is a sex offender who complained about information in a Security Information Report about him. He said the information was untrue, and was impeding his progress through the system as well as affecting his privacy. He suggested that, if the allegations in the report could have been supported, further action would have been taken. Mr Y also suggested that the report was made maliciously following an argument with another prisoner.

My investigator found that a prison officer had reported to security that Mr Y was among a number of men attempting to groom other prisoners for sexual liaisons. The original source of the information was not recorded, and on this basis the information was not considered to be completely reliable. Consequently, the security manager decided to take no disciplinary action. However, he also decided to monitor Mr Y closely, in particular by requiring his cell door to remain fully open during in-cell association.

The Prison Service relies upon security information to ensure that prisons are safe and ordered. It is the responsibility of the security manager to ensure that suitable arrangements are in place to gather, update and disseminate security information, and Security Information Reports are the main method of doing so. The Prison Service's National Security Framework requires that all information should be evaluated by a properly trained member of staff and acted on accordingly. Given the nature of Mr Y's offence, and the possible risk he was considered to pose to other prisoners, I was satisfied that the information had been evaluated and used appropriately. I did not uphold Mr Y's complaint.

Mr Z complained that his mental health deteriorated shortly after he was sent to prison, and that he received little in the way of treatment. Mr Z said it had taken five months to arrange his transfer to a psychiatric hospital after he was sectioned under the Mental Health Act. He said the lack of care had caused him to self-harm and attempt to take his own life.

There is no doubt that there are many people in prison, like Mr Z, whose care would be more certain in a mental hospital. In Mr Z's case, it was clear that for a number of months his situation dominated the thinking in his prison. He was first located on the healthcare wing where a governor saw him almost daily, and there were a number of meetings to consider the best way of caring for him. Mr Z was sectioned under the Mental Health Act and a place found for him in a secure unit. However, the placement was withdrawn when Mr Z assaulted a member of prison staff. At that stage he was transferred to the segregation unit. Despite pressure from the prison's management, no other place could be found until the prison prevailed upon the local PCT to find Mr Z a place in a private psychiatric unit and he was transferred.

Staff in the segregation unit found the deterioration in Mr Z's condition distressing and frustrating. However, the medical records that my investigator considered (with Mr Z's permission) indicated that he had received a high standard of care. So much so that a visiting consultant psychiatrist had commended the staff for their work and record keeping. The consultant said that, had it not been for the observations and subsequent referral by the officers who were involved with Mr Z, he would not have received an appropriate assessment nor benefited from the transfer he so clearly required.

I was in no doubt that Mr Z should have been transferred at a much earlier stage. But it was also clear that the prison had done all it could to find a suitable placement for him outside the prison system, and to provide the necessary care in the meantime. On these grounds, I did not uphold Mr Z's complaint.

Early release

Mr AA was a juvenile held in a Young Offender Institution (YOI). He complained that he had been refused presumptive early release. Those serving a detention and training order are normally released early unless there are exceptional circumstances such as persistent serious indiscipline or violence.

Mr AA had breached the YOI's anti-smoking policy by smoking while on an outside project. I considered that the loss of the placement was more than sufficient punishment, and that the decision to keep Mr AA in custody did not meet the criteria for refusing presumptive early release.

Mr AA had already served a month beyond the date on which he could have been released, and I wrote immediately to the Prison Service. My recommendation that Mr AA be released was accepted and he was freed later that day.

Mr BB, a prisoner serving four years and one day for an offence that was neither sexual nor violent, complained that he had been refused early release under the Home Detention Curfew (HDC) scheme despite the exceptional circumstances surrounding his application.

In 2006, a Prison Service Instruction (PSI) took account of the provisions in the Criminal Justice Act (CJA) 2003 making prisoners serving four years or more unsuitable for HDC unless exceptional circumstances prevailed.

The PSI said it was impossible to give guidance on what would constitute exceptional circumstances but they would stand out. The PSI gave one example of features that would amount to exceptional circumstances – the likelihood of re-offending is extremely small, and the prisoner has no previous convictions, and the applicant is infirm by disability or age – but stated that Governors should exercise their discretion. If a Governor believes an individual should be released early, irrespective of the length of sentence, the matter must be referred to the National Offender Management Service (NOMS) for final approval. In Mr BB's case, NOMS had refused the application.

I discovered that this was Mr BB's first conviction. He had behaved impeccably in prison and received positive reports throughout his sentence. He was said to have made excellent progress and had been

successfully released under a number of temporary licences. In addition, Mr BB was an amputee and a wheelchair user. He had disabilities in all his limbs and a chest condition that made it difficult for him to breathe easily.

Decisions of this nature can never be easy or clear cut. They must finely balance the potential benefits to the prisoner against any possible risk to the public and confidence in the HDC scheme. Nevertheless, I found it difficult to understand why Mr BB's case was not considered exceptional. Indeed, it seemed to me that if he did not qualify as an exception, no one would. Given the progress he had made and bearing in mind the prison population pressures and overcrowded conditions, I could see no reason for him to remain in prison any longer.

Mr CC also complained that he had been turned down for HDC. He was serving two years for an offence in the 'presumed unsuitable' category and the Governor did not consider his circumstances to be exceptional.

My investigator found that Mr CC had a previously unblemished record and was considered to pose little risk. He had testimonials indicating that he was known in his community as a respected and decent man who had acted out of character. Like Mr BB, he had behaved in an exemplary fashion in prison and had made good progress. My investigator confirmed that Mr CC had been the main carer for elderly, infirm parents, a wife who had recently

undergone heart surgery, and a young son with special educational needs.

There are many prisoners with responsibility for children or sick relatives, but in Mr CC's case there were four family members suffering serious health problems and Mr CC's absence had a profound effect. When this was added to the fact that Mr CC himself met two out of the three suggested criteria for exceptional circumstances, I believed that his case could certainly be described in such terms.

More generally, I believed there was a need for a fresh look at HDC eligibility. It had been some years since the introduction of the 'presumed ineligible' policy, during which

time the new end of custody licence arrangements had been implemented. I suggested that the task could be less onerous for Governors if they were provided with more detailed guidelines, and in the cases of both Mr BB and Mr CC I recommended that NOMS should review the position on exceptional circumstances. I am pleased to report that moves are under way to carry out such a review.

On probation

In the reporting year I received a total of 426 complaints about the Probation Service, an increase of no less than one-third. However, the pattern of previous years was repeated in that only 37 (9 per cent) of those complaints were eligible for me to investigate. Of the remaining 91 per cent, most potential complainants had failed to complete the National Probation Service's (NPS's) own complaints procedures.

I am disappointed to record that some probation areas still seem not to have adopted an open approach towards complaints. I have seen a number of complaints where extra stages to the procedure have been included, and others where grievances have been treated as inquiries. The overall result is that the system is made more complicated than is necessary. I am well aware of the demands placed upon probation staff, and the resources needed to investigate complaints thoroughly. However, I hope that the

new arrangements under the National Offender Management Service may encourage a more open approach.

Mr DD complained that the probation area disclosed details of his previous convictions to a prospective employer. He said this was unfair and had prevented him from obtaining a job. Mr DD believed that, unless a prospective employer directly asked him about previous convictions, he was not obliged to disclose them. By doing so, he said the probation area had breached confidentiality.

The NPS works with some of the most dangerous offenders in the country and the need to make informed assessments of risk is crucial. It is not always easy for offenders to accept such assessments, particularly when they affect their daily lives. But the requirement to protect the public from the consequences of offending remains a central focus of the NPS's

work, and Multi Agency Public Protection Arrangements (MAPPA) enable information to be shared and acted upon quickly. Nevertheless, the duty to protect the public must be carefully weighed against the rights of individuals, and disclosure of personal information must be handled sensitively.

The Rehabilitation of Offenders Act 1974 governs the disclosure of previous convictions in an employee/employer situation. However, Mr DD was a sex offender subject to the provisions of MAPPA. In Mr DD's case I was satisfied that the nature of his offence, together with the risk he was assessed as posing, made it appropriate for the probation area to use its discretion to inform the prospective employer of his conviction. Although the action jeopardised Mr DD's prospects of gaining employment, this was subsidiary to the need to protect the public.

Mr EE complained about a number of issues, one of which was that the probation area refused to disclose to him details of his Offender Assessment (OASys). He said that, under the terms of the Data Protection Act, he was entitled to see the information held on him. Mr EE suggested that several of the probation area's staff were involved in a conspiracy against him.

My investigation found that there had been a breakdown in processes when Mr EE asked for his OASys. There was confidential third party information in the original form that could not be disclosed, and it was necessary to rewrite the form excluding these details. But this did not account for the time Mr EE had been denied access to the information, and it was not possible to discover exactly what had gone wrong. However, during their internal investigation the probation area had acknowledged the unacceptable delay and apologised. They had also taken steps to ensure

similar hold-ups did not occur in the future. I upheld this aspect of Mr EE's complaint, and asked the probation area to remind staff that only information that may be disclosed to offenders is included in OASys forms.

Mr FF complained about a report for his parole hearing written by a Senior Probation Officer (SPO) against whom he had previously complained. He suggested that the officer was biased, and said the report should have been written by another officer, particularly as he had refused to be interviewed by the SPO. Mr FF was concerned about the reasons given for not recommending his early release and the importance given to his non-completion of a Sex Offender Treatment Programme.

I discovered that Mr FF had done little during his sentence to address his offending behaviour. Moreover, those courses he had completed were unlikely to have a significant impact on his life when he was released. Consequently, I agreed with the SPO that the risks he posed at the time of sentence remained unchanged. Based on this fact alone, I agreed with the SPO's conclusion that Mr FF continued to pose a very high risk to children and should therefore not be released early. However, although the report indicated that Mr FF would seek out other victims when released, the SPO acknowledged that this was her opinion rather than something Mr FF had said directly. I did not consider her opinion to be inconsistent with the factors applying in Mr FF's case, and neither did I consider that the SPO had intended to deliberately mislead. But on such a crucial point I considered that more care should have been taken over the use of words. It was impossible to say whether this one inaccuracy was responsible for the Parole Board's decision not to grant parole – on the balance of probability I thought it unlikely. I did not uphold Mr FF's complaint.

Mr GG complained that the probation area responsible for his supervision refused to transfer his case to an area where he could provide an address and family support. He said he wanted time to make a relationship with an offender manager from the new area, and was being prevented from doing so. He suggested that his current area wished to influence decisions about his sentence and was refusing transfer only so that they might do so.

I have received a number of complaints from prisoners who wish to live in a different area upon their release and who find that one probation area refuses to transfer their case to another. Some find it difficult to accept that probation areas will only agree to the transfer of cases if they can provide addresses that are suitable and do not conflict with any licence conditions. When offenders are to be supervised under MAPPA, considerations about the management of risk override any personal preferences.

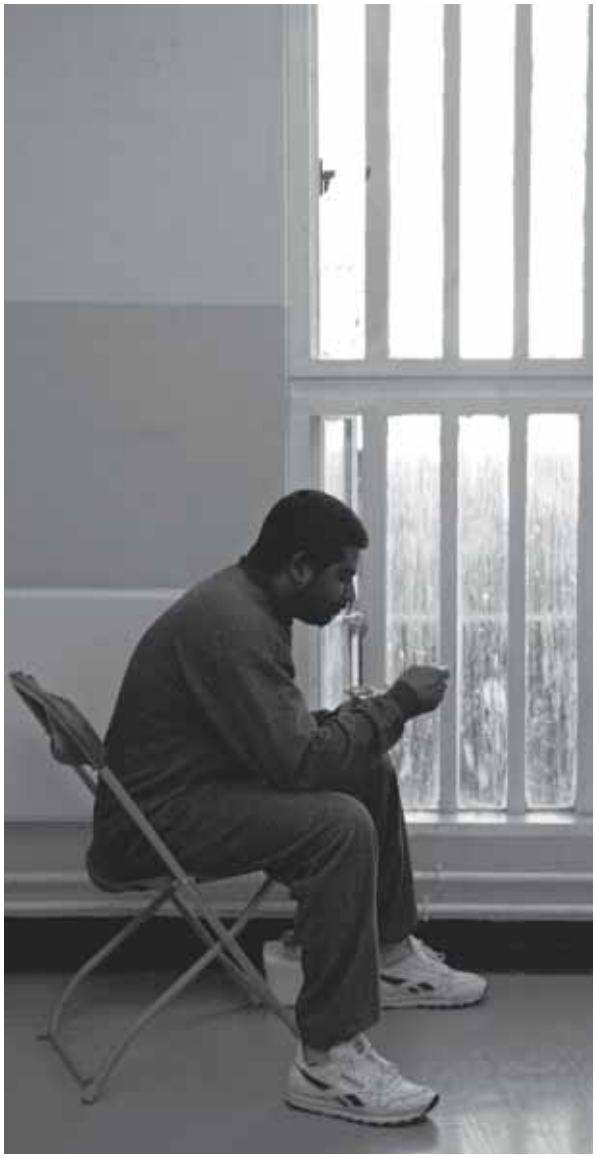
In the case of Mr GG, my investigation found that the probation area did not object to transferring his

supervision and had done nothing to obstruct it. On the contrary, they had contacted the new area on two occasions about the transfer of Mr GG's case. Each time they were told that the new area would consider transfer but only nearer the date of Mr GG's proposed release. While I accepted the logic of Mr GG's argument about establishing a working relationship as soon as possible, I did not find that his current area was at fault as there was nothing more they could do to influence the decision.

Immigration detainees

This is the first full reporting year in which I have been responsible for investigating complaints from detainees in Immigration Removal Centres (IRCs). During the year I received 93 complaints from across the removal estate. A number of those who contacted me complained about issues outside my remit such as their immigration status or their future after removal, while others had not given the IRC the opportunity to consider the complaint. Nevertheless, 49 complaints were eligible for me to investigate, and I anticipate the numbers rising in future years as my role becomes better known.

Complaints covered a broad spectrum of issues from allegations of bullying and assault to food, escorts, property and regime activities. I also received a number of complaints about the use of Control and Restraint (C&R) procedures. I do not underestimate the difficulties IRC staff sometimes face



from detainees, but the use of force must be an act of last resort, and must be properly regulated and monitored.

Ms HH complained of assault and maltreatment. She had been detained in her IRC's induction unit, during which time her asylum claim and an appeal were both dismissed by the immigration authorities. Due to pressure of numbers, it was necessary for Ms HH to be relocated from the induction unit to a normal wing.

My investigation found that staff had given Ms HH prior warning that she would be relocated, but she had refused to move. She subsequently locked herself in another detainee's bathroom in her underwear, and tried to enlist the help of other detainees. Not surprisingly, this was considered disruptive to the good order of the IRC and it was judged necessary for staff to carry out C&R procedures to remove her. A healthcare practitioner and manager supervised the move, and CCTV evidence confirmed that undue force had not been used. However, my investigation also found that Ms HH had been left in her underwear in the IRC's secure unit for approximately two hours. Although I judged that no more force than was necessary was used to transfer Ms HH from the induction unit, I reminded staff of the need to preserve the dignity of detainees – both when C&R procedures are invoked and afterwards.

Mr JJ complained about the findings of an internal Border and Immigration Agency investigation into the force used in moving him from his room.

Mr JJ was to be transferred to another IRC and it was alleged that he had resisted three previous attempts to move him. In the early hours of the morning, he was taken by staff from his room. He was partially dressed and sustained a minor injury. Mr JJ claimed he was not given the opportunity to comply before staff used unnecessary force to remove him, using batons to beat him about his body. He said he was placed in a cold room in only his boxer shorts.

The use of video equipment is a requirement whenever a planned C&R operation is to take place. Although my investigator found evidence to suggest staff had used approved techniques, there was no supporting

video evidence. As Mr JJ had exhibited no bruising immediately after the event, his allegation of being beaten with batons was not supported and I could not uphold his complaint of assault. However, I brought the shortcomings in respect of video coverage to the attention of managers so that something similar could not occur again. Moreover, there was no doubt that Mr JJ had been left for some time in a cold room in his underwear – a situation both undignified and possibly injurious to his health. I upheld this aspect of his complaint.

Mr KK complained that he could not obtain a transfer to a different IRC.

By the time I investigated this case, Mr KK had successfully been transferred. However, this was only after staff had made four transfer applications to the Detention Estate and Population Management Unit (DEPMU). I discovered that DEPMU did not as a matter of routine explain to IRC managers why detainee transfer requests were unsuccessful. I also found that there were difficulties in transferring detainees to particular IRCs because of capacity issues. I asked DEPMU to provide better information to IRC managers so they are able to inform detainees if their transfer requests cannot be met.

Mr LL complained that some of his property went missing while he was resident in an IRC.

Mr LL said that, when he was relocated from one room to another, he was not given the option to pack his belongings. He was told that arrangements would be made for them to follow him. According to Mr LL, when his property eventually arrived, a number of items were missing. Mr LL subsequently provided staff with a list of these items and a monetary value of more than £500.

My investigation found discrepancies between the property listed on Mr LL's property card and what he claimed was missing. These meant I was unable to uphold his complaint. However, I found procedural inefficiencies in the way staff had dealt with his complaint. There was little evidence that the IRC had proper procedures in place to handle Mr LL's complaint and this meant a less effective and more time-consuming investigation all round. I have reminded IRC managers of the need to have processes in place to assist with all investigations.

INVESTIGATING FATAL INCIDENTS

Since 2004, the PPO office has been entrusted with what I believe may be a unique responsibility: a standing commission to investigate every death in prison. We also investigate deaths occurring in immigration detention and among the residents of Approved Premises (probation hostels).

I also have the authority to investigate deaths occurring after release from custody although, as I have said in the foreword to this Report, in practice I simply do not have the resources to do so.

During 2007–08, the number of deaths in prison increased from 162 in 2006–07 to 183 and those among Approved Premises residents grew from 14 to 17. The increase applies to deaths from natural causes as well as those that were apparently self-inflicted. Those who took their own lives included one 15-year-old boy.

The number of deaths has meant a high caseload for each of my investigators and increased pressure of work. (It has presented another problem in that I do not want investigators to become too accustomed to investigating in specific establishments.)

My management information systems have been rudimentary – this should improve during 2008–09 with the introduction of a new Case Management System – but I have not needed anything very sophisticated to know that reports are sometimes late. I very much regret the impact these delays have on bereaved families, the services under investigation and the Coroner. All colleagues are conscious of the need to improve performance.

The pressure on staff has been exacerbated by a shortage of managers. Those who lead the fatal incident investigation teams have a critical role in validating the investigation at every stage. New appointments were forthcoming as the reporting year came to a close.

The extent to which the rising number of prison deaths may have reflected population pressures has been widely debated. Indeed, overcrowding has been argued to be both a cause of and a protection against suicide and self-harm. My own view is that the term 'overcrowding' is unhelpful in this respect. The focus should be instead upon turnover, the frequency of moves between prisons, the time at night when prisoners are received, the continuity (or otherwise) of their medication, and the simple amount of time that staff may devote to prisoners' individual needs. I have investigated the deaths of several prisoners who were evidently disadvantaged by their enforced transfer between prisons because of overcrowding pressures.

It has long been recognised that prisoners are at greater risk of suicide and self-harm during the first days and weeks in custody,[4] and this year has been no exception. With that in mind, I have asked myself whether a means could be found to feed back the findings of my investigations to the judiciary. Regardless of the merits of the original remand or sentencing decision, it seems right that those making such decisions should be informed of what has occurred.

> "I have investigated the deaths of several prisoners who were evidently disadvantaged by their enforced transfer."

However, I have also been very aware this year of the higher number

of deaths in category C prisons, and among those well into their sentences. The deaths of those serving indeterminate sentences, women prisoners and foreign nationals have also caused particular concern (I report on these in more detail later). Finally, I have investigated the deaths of two prisoners that occurred before they reached prison and while they were still in the court precincts. One was due to natural causes and the other was apparently self-inflicted.

Notwithstanding the day-to-day pressures of fatal incident investigations, liaison with our stakeholders is increasingly important and positive. At a senior level we are core members of the Ministerial Roundtable on Suicides and the Forum for Preventing Deaths

[4] '…the tendency to commit suicide is greater during the first week of imprisonment than at any subsequent period.' Stephen Hobhouse and Fenner Brockway, *English Prisons Today,* 1922.

in Custody. In addition, my Deputy Ombudsman for Fatal Incident Investigations shares responsibility for the PPO/Safer Custody and Offender Policy Group liaison meeting. This is an invaluable forum for discussing the learning from investigations with the services in remit and with Offender Health. As noted earlier, we have also taken the first steps to drawing up a Memorandum of Understanding with the Coroners Society, and will shortly resume our meetings with Inquest.

One of the results of our liaison with Offender Health has been their analysis of the most significant healthcare themes within our reports. (The comments below refer solely to deaths in custody.) The eight themes are to be circulated to PCTs but merit a wider audience and so I reproduce them here:

1. **All Department of Health and National Health Service policies apply to prisons**

Shortfalls include:

- little evidence of the application of the Care Programme Approach for prisoners who are seriously mentally ill
- the need to improve chronic disease management
- the importance of avoiding interrupting long-term medication when a prisoner comes into custody.

2. **The need for deployment of a high quality, skilled and experienced workforce**

Reports frequently highlight deficiencies in medical and nursing skills and training.

3. **Every new policy and modernisation technique should be applied to the prison setting**

PCTs sometimes omit the prison when new legislation, policies and performance monitoring are introduced. For example, the disability legislation and waiting time targets apply to prisoners as well as the rest of the population. Improving health inequalities is a key target for the NHS which could help to reduce re-offending and reduce the number of deaths in custody.

4. Improve continuity of care

Recurring themes include:

- transferring records as prisoners come into prison or move between prisons
- improving record keeping.

5. Dealing with poor performance

Poor clinical professional performance is not always recognised or properly addressed.

6. Promoting an integrated approach to the care of people in prisons

Healthcare and discipline staff may have different aims and structures and do not always work together to improve the care of prisoners. Lack of joint working can increase the risk of deaths in custody. For example, sharing information about mentally ill prisoners increases the chance of identifying changes in mood and warning signs.

7. Improve management processes

Healthcare managers should ensure that their staff, including those working for agencies, are familiar with prison systems such as ACCT (Assessment, Care in Custody and Teamwork – the Prison Service's system for monitoring and supporting those believed to be at risk of self-harm or suicide).

8. All deaths in custody should be reported as Serious Untoward Incidents (SUIs)

All deaths in custody are referred to the Coroner and are considered to be Serious Untoward Incidents, which is the NHS terminology for such events.

The PPO office looks forward to working with Health Service colleagues and others on the demanding agenda represented by these eight themes.

Foreign national prisoners

In the last decade, the number of foreign national prisoners has doubled. They now represent 14 per cent of the total prison population in England and Wales. Prisoners with diverse religious and cultural needs, or those for whom English is not their first language, present self-evident challenges for the staff charged with their care. For the prisoners themselves, along with the deprivations that incarceration inevitably brings with it, there are likely to be additional pressures of isolation and concern about immigration status.

The Prison Service deserves greater credit than it has received for its efforts to meet the needs of foreign national prisoners. However, a survey conducted by HM Chief Inspector of Prisons for her 2006–07 Annual Report indicated that nearly a quarter of foreign nationals arrived in prison feeling depressed or suicidal, and hardly any of those surveyed knew how to contact a Listener (a prisoner trained by the Samaritans to offer confidential emotional support to fellow prisoners in distress). A quarter

of all apparently self-inflicted deaths in prison investigated in 2007–08 involved a foreign national, an increase of 22 per cent from the previous year.

Mr MM was charged with the murder of his wife and remanded in custody. His two children were taken into care and he had no other family in the UK. Mr MM's understanding and use of English were very limited.

Mr MM spent some time in the prison's healthcare centre. He was on an open ACCT document until a week before his discharge from healthcare. The day after the ACCT post-closure review was carried out, he was moved to normal location on a residential wing. There was no record of any significant staff contact with him over the next four weeks until he was found hanging from his cell window bars.

My investigation is ongoing but the indications are that the prison had recorded only the most basic information about Mr MM and did not appear to provide any formalised support for foreign national prisoners. There seems to be no indication whether the impact of having his children taken into care was considered, or whether Mr MM fully understood their situation.

Indeterminate sentences

During 2007–08, the indeterminate sentence of imprisonment for public protection (IPP) has been the subject

of much media coverage. The number of prisoners serving life has increased and the effects upon the Prison Service have been considerable. Many IPP prisoners face delays in being transferred to access courses and programmes necessary to reduce their risk factors and hence be favourably considered for parole. It is self-evident that the uncertainty of their situation may affect their mental well-being.

Mr NN was a repeat offender. His prolific self-harming and personality disorder meant that he had difficulty coping with any prison regime. When he received an indeterminate sentence with a three-year tariff, he told relatives how difficult it would be for him.

Mr NN's transfer to the lifer estate was prioritised but the sentence planning

process took time. Meanwhile, he received support from the prison's mental health team who indicated that he would be referred to a local secure psychiatric unit. There was evidence that Mr NN felt overwhelmed by the choice of finally confronting his mental health problems on the one hand and the demands of the indeterminate sentence on the other. Mr NN was discovered dead in his cell, apparently having strangled himself.

Mr PP was sentenced to life imprisonment with a minimum term (tariff) of 14 years. He was sent from court to a local prison where he awaited a transfer to the lifer estate.

Mr PP was anxious to start addressing his offending behaviour and work towards gaining his release on life licence. However, with limited spaces in the lifer estate, IPP prisoners with short tariffs have been prioritised over those serving mandatory life sentences. Transfers have taken much longer than many prisoners had expected. While continuing to await his transfer, Mr PP apparently took his own life.

Deaths of women prisoners

Publication in March 2007 of Baroness Jean Corston's review of women with particular vulnerabilities in the criminal justice system has raised questions as to the suitability of mainstream prisons for women with serious mental health and/or drug addictions. The Corston report followed a series of six self-inflicted deaths of women prisoners at HMP Styal between August 2002 and August 2003 (which I investigated), and the subsequent inquests held by the Cheshire Coroner. Judged on any criterion, women prisoners are a particularly at-risk group. The majority enter prison with histories of physical and sexual abuse, mental health problems and addictions, or a combination of all of these. Jean Corston writes in the foreword to her report as follows: *'There are many women in prison, either on remand or serving sentences for minor, non-violent offences, for whom prison is both disproportionate and inappropriate.'* I entirely agree.

Jean Corston had been encouraged by the decline in the number of apparent suicides of women prisoners over the period between 2003 and 2006. (There were 14 such deaths in 2003, 13 in 2004, four in 2005 and three in 2006.) Sadly, the number of apparently self-inflicted deaths of women prisoners increased in 2007 and eight women died at their own hand (six in the reporting year of 2007–08).

The relevance and significance of the Corston report is highlighted by a number of the investigations I have conducted after deaths in female prisons. Her report noted:

- Drug addiction plays a disproportionate part in female offending.

- Mental health problems are far more prevalent among women in prison than in the male prison population or in the population at large.
- Outside prison, men are more likely to commit suicide than women. In prison, the proportions are reversed.
- Women prisoners are far more likely than men to be primary carers of young children, and this makes the prison experience significantly different for them.

A number of the features highlighted by Baroness Corston are immediately observable in **Ms RR**'s case. She was returned to prison because she had not complied with her licence conditions. She had resumed taking drugs after her release. She also had a long history of mental health problems for which she had been treated as an inpatient on many occasions. (At the time of her recall, she was under the care of a psychiatrist and a community psychiatric nurse.)

When she came back to prison Ms RR wanted to detoxify from methadone despite advice from staff that it would be better for her to remain on a maintenance programme. She was worried about her daughter's welfare and an Assessment, Care in Custody and Teamwork (ACCT) document was opened on a number of occasions.

Ms RR had self-harmed in police custody. In the two weeks before her death she self-harmed on a number of occasions using ligatures and

by cutting herself. On one occasion she was taken to outside hospital for treatment.

Following an aggressive incident on the day she died, Ms RR was relocated in a special cell in the prison's segregation unit. She was observed for some time and persuaded to move to a normal cell. Soon afterwards, Ms RR was found hanging in that cell and she died the same day in a nearby hospital.

In the introduction to my report on Ms RR's death I wrote as follows:

'All my reports are about the deaths of individuals. However, I am very conscious that Ms RR was all too representative of the very many damaged and vulnerable women who end up in this and the other women's prisons. Much of the focus of the Corston report was on the needs of women with mental health and drug problems and the development of alternative, more therapeutic, more women centred approaches to their treatment and rehabilitation. The sad death of Ms RR serves to emphasise the importance of Baroness Corston's findings and recommendations.'

Drug use and addiction is a feature of much female offending. The case of Ms SS is a vivid illustration of the pernicious power of drugs.

Ms SS had misused illegal drugs from a very young age. She had referred herself to several community agencies to assist her to remain drug free but, at the time of the arrest leading to her first custodial sentence of two years' imprisonment, she had resumed taking drugs once again.

Two months before her death Ms SS was transferred to an open prison so that she could be better prepared for her eventual return to the community. She took a number of steps to address her drug use, including completing a detoxification programme and relapse prevention work with a counsellor. Ms SS completed successful releases from prison on temporary licence (ROTL) as part of her resettlement. These included two day release town visits and one overnight weekend visit to her parents' home. On her last ROTL, a week or so before her expected release from prison on parole licence, Ms SS was found dead in bed in her parents' house. Drugs paraphernalia were found next to her.

Return to the community after a period of imprisonment is an intensely risky period for anyone who has

previously engaged in substance misuse. The body's tolerance to the former drug of preference is greatly reduced after a period of enforced abstinence. With distressing regularity I am asked to conduct investigations where the cause of death is drug misuse in the critical first few weeks after release from prison. (In practice, as I have said earlier, I can take on only a tiny number of these discretionary investigations; I have no resources to do otherwise.) In the conclusion to my report on Ms SS, I said she had received kindness and support from the Prison Service and appeared to have responded well. Sadly, kindness and support may not be sufficient to overcome many years of addictive and self-destructive behaviour.

Deaths from natural causes

Research confirms that the mortality rate of prisoners in England and Wales is higher than for the general population. I am grateful to the Offender Health team at the Department of Health for sharing their analysis of 120 of the cases I have investigated since 2004.

A particularly sad feature of the natural cause deaths is the comparatively young age of the prisoners who have died. Almost 70 per cent of those who died of natural causes during 2007–08 were aged 60 or below and the youngest was only 20. To some extent, this must reflect the age structure of the prison population as a whole, and the number of prisoners who have abused drink and drugs or who continue to smoke. The majority of those who died were not suffering with a chronic condition and my investigations indicated that their deaths could not have been predicted.

Mr TT was 40 years of age and suffered with diabetes that required insulin treatment. In the community he had led an unstable life, and since coming into prison he had not co-operated with staff who tried to manage his condition.

A few weeks into his sentence, Mr TT complained to wing staff that he was suffering from chest pains. He was examined by a nurse who found nothing of immediate concern but nevertheless arranged for him to be assessed by a doctor as soon as possible the same day. An hour or so later, two officers went to collect Mr TT for his

doctor's appointment but found he had collapsed. He was motionless and unresponsive. Attempts to resuscitate him were unsuccessful, and it was later found that he had suffered a heart attack.

My investigation concluded that the prison had provided a high standard of care for Mr TT's diabetes, although he had not taken sufficient advantage of the treatment offered. Mr TT had neglected his health in the community and continued to do so during his sentence. The long-term effects of this neglect were damage to his heart and other organs. Although I concluded it was unlikely that Mr TT's death could have been prevented, I recommended that staff should be trained to recognise the signs and symptoms of severe chest pain and how it might be best managed.

Unfortunately, Mr TT was typical of a number of prisoners whose lifestyle in the community includes limited use of healthcare. For such people prison can provide an opportunity to screen and treat their illnesses. Regrettably, the long-term damage to Mr TT's health was such that for him the treatment came too late. I have been pleased to learn that the Offender Health team is considering further research into deaths like that of Mr TT to identify ways in which they might be prevented.

Approved Premises

This year the number of deaths of residents of Approved Premises increased from 14 in 2006–07 to 17 in 2007–08. Nine deaths were due to natural causes, two residents died because of substance misuse (compared

with six last year), and six apparently took their own lives (as opposed to one in the last reporting year). One of those to die from a drug overdose was a woman.

My investigations have highlighted three main areas of concern. The first is Assessment, Care and Teamwork (ACT), the suicide and self-harm monitoring procedure adapted from Prison Service arrangements and adopted in three probation regions. I have expressed some misgivings about ACT – not for its aims, which are admirable, but because the supervising offender manager is not included in the process. However, I am pleased that a review of ACT has now been commissioned and look forward to hearing the outcome.

One apparently self-inflicted death occurred on a resident's first night in an Approved Premises that did not operate ACT arrangements. I made four recommendations, all of which were accepted:

- information should be obtained from the prison if a recently released resident admits previous self-harm
- the provision of suicide and self-harm awareness training should be reviewed
- the probation area should consider introducing a tool to assess the resident's risk of suicide and self-harm (as happens before a prisoner's first night in custody)
- the manager could supply ligature knives (which safely cut through ligatures).

The second area of concern focuses on the needs of older residents. In my experience, Approved Premises are rarely equipped or staffed to cater for the needs of older people. Almost half (45 of 101) have a room suitable for someone with a disability, but the accommodation is in short supply and staff are not trained to provide the lifting and personal care that may be required. My investigations have shown that managers can spend considerable time negotiating for resources with local social and healthcare providers.

Mr VV was released from custody to an Approved Premises where he stayed for 11 months until he died. The manager had reservations about taking Mr VV but was persuaded to do so as it would be a short-term placement. Mr VV had complex health needs that required frequent attention from his doctor and regular outpatient appointments. On more than one occasion he refused to take his prescribed medication. Applications were made for local authority housing but his licence expired before he was rehoused. As he had nowhere else to go, Mr VV continued to occupy a scarce Approved Premises place.

The manager and staff had provided excellent care for Mr VV in difficult circumstances and I was pleased to commend them. I recommended that

the probation area and local housing providers should review the availability of appropriate accommodation for residents who are no longer on licence.

My final concern is one I have mentioned on a number of occasions since I began investigating deaths in Approved Premises. It concerns residents' access to medication. The current standard practice is for medication to be held and administered by staff. This is despite the fact that many residents will have been responsible for their own medication while they were in prison. I am pleased that the National Offender Management Service (NOMS) has set up a pilot to determine if residents can safely take charge of their own prescribed medication.

The response of probation areas and NOMS to my recommendations remains positive, and national guidance has often followed. It is also encouraging that HM Chief Inspector of Probation has incorporated my recommendations into the inspection methodology for Approved Premises. This means that my office's findings following the very rare tragedies can influence practice in hostels throughout England and Wales.

Work with bereaved families

In all my investigations of fatal incidents, I am committed to involving bereaved families in ways that are sensitive to their needs at the most difficult of times. To that end, my team of family liaison officers (FLOs) has a crucial role to play, providing the link between investigators and the families of those who have died. As an indication of the importance that I attach to this work, I have reallocated resources to enable the recruitment of a fifth FLO.

FLOs work with families at five stages of the investigation:

- identifying the family's questions and issues
- ensuring that reports are understandable and answer those questions
- ensuring that the family's comments are taken into consideration at the draft report stage
- ensuring that final reports are presented sensitively to families
- consulting families about the publication of anonymised reports.

Before contacting any family an FLO will obtain as much background information as possible to ensure that the initial contact is appropriate and timely and meets the family's needs. It may be necessary for the approach to be made through a third party such as a victim liaison officer, a social worker or a solicitor, particularly when the family may want additional support. There have also been cases where the next of kin is in prison too, and FLOs have had to balance issues of confidentiality and the individual's right to privacy with the need to ensure that appropriate support

can be made available when reports are received.

Following the death of **Mr WW**, at the request of the Prison Service my FLO visited a family member who was a prisoner as there were concerns about his welfare. The Safer Custody Manager felt that it would be in the prisoner's best interests to be given the opportunity to meet, in confidence, directly with my investigation team. After their visit, the FLO and investigator were sufficiently concerned to add an entry into the prisoner's own ACCT form, to ensure that he could be given the necessary additional care and support in the immediate aftermath of his relative's death.

When those who die are foreign nationals, FLOs will still do all they can to make contact and engage with the bereaved family. In some cases they have made contact through diplomatic channels; indeed, in one case all contact with two different groups of family members was conducted via a designated member of a foreign embassy. FLOs have also worked with community leaders to ensure that the families of foreign national prisoners are fully involved in the investigation process.

If families do not have English as their first language, FLOs have access to translation services. Inevitably, cases where translated documents need to be sent overseas take longer to move between key stages. I encourage all my investigators to use plain English but when documents are to be translated, there is a particular need to avoid the use of jargon.

In **Mr XX**'s case, my draft report contained a reference to the use of 'restraints'. When speaking to the family overseas through a translator, it became clear to the FLO that the family interpreted this word to mean something far more coercive and restrictive than it is. The thought of their family member being treated in such a way had caused great distress, and the FLO then put considerable effort into explaining what we meant by the term.

During the year, the FLO team has established good links with a number of organisations working with prisoners and bereaved families. They have welcomed the opportunity of speaking at conferences, sharing what we do and learning from the experience of others. The team has built upon these solid foundations by linking with the family liaison sub-group of the Forum for Preventing Deaths in Custody. In the coming year we will seek further opportunities for shared learning and training. We are also developing methods for families to tell us what they think about my office's involvement.

SPECIAL INVESTIGATIONS

I reported last year on an investigation I had been commissioned by the Secretary of State to chair regarding the circumstances of what the Court of Appeal called the 'near suicide' of Mr D.[5] My terms of reference partly reflect those used when I investigate a death in custody, but I have also been asked to consider the implications for future investigations into near-deaths.

The report of my investigation had not been finalised by the end of the reporting year, but all the evidence-gathering had been completed.

Mr D was a 21-year-old man who was remanded to Pentonville in 2001. He had a history of self-harm and tried to harm himself several times while in prison. A serious hanging attempt resulted in brain damage and it is unlikely he will ever be well enough to return to the community.

Because no previous Article 2-compliant investigation into a near death in prison had been conducted, to a very large extent I had to design appropriate procedures as I went along. In doing so, I was guided by what I consider to be the principles of fairness, transparency, and an inquisitorial not adversarial approach.

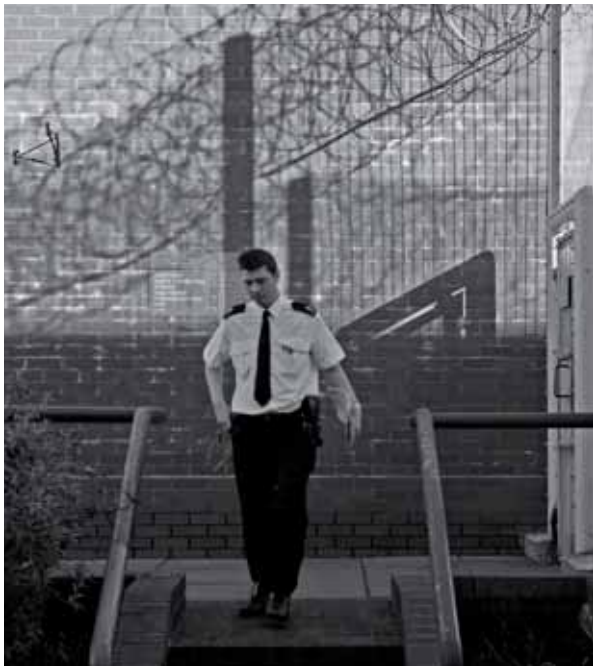
In conducting the investigation, I sought to adopt procedures that were proportionate and that provided proper value for money for the taxpayer. However, the investigation has taken almost two years to complete (I had originally envisaged it would need around six months). It also became unduly legalistic, and its total cost (made up in very large part by the parties' legal bills) may well have exceeded £0.5 million. I believe this was disproportionate to the facts of this case, given that Mr D's entire prison record could not be found and staff could remember little of him. In any event, such a sum would prove ruinous were it to apply to all future inquiries into near deaths in custody.

At an early stage of the investigation, Mr D's representatives asked me to appoint a clinical expert to the inquiry.

[5]A landmark judgment by the Court of Appeal (*R (D) v Secretary of State for the Home Department* [2006] EWCA Civ 143) determined that an internal Prison Service investigation was not sufficient to meet Mr D's rights under Article 2 of the European Convention on Human Rights. I was therefore commissioned to conduct an Article 2-compliant inquiry.

Given the paucity of contemporaneous medical records, I declined. My judgement was that there was little on which such an expert could comment usefully or with any real certainty. I remain of the view that my initial assessment was not unreasonable. In the event, however, Mr D's representatives commissioned their own clinical review, as subsequently did the Prison Service. Both contributed very significantly to the inquiry, and I now think that it might have been better had the inquiry commissioned its own expert(s) in the first place. This is an important lesson for any Article 2-compliant inquiries that may take place in the future.

The preliminary part of the investigation entailed obtaining such documents as could be found and interviewing staff who were named in those documents or who were known to have had some management of Mr D. Having reviewed the evidence gathered during the first stage of the investigation, I drew up a list of witnesses to give evidence at hearings. (This was – alongside my publication of relevant material on my website – to satisfy the Article 2 requirement for a public element to the investigation.) This and lines of questioning were agreed with both the Prison Service and those representing Mr D.



Hearings were held over eight days in July and November 2007. The hearings were recorded and simultaneously transcribed using LiveNote technology. Each of the parties opened with a formal submission, before Counsel to the inquiry put questions to witnesses on my behalf. No cross-examination of witnesses was allowed and I sought to keep proceedings as informal and inquisitorial (as opposed to adversarial) as possible. However, those representing the Prison Service and Mr D were invited to suggest any further questions for Counsel to the inquiry to put to each witness, and to submit written closing statements. The former was an innovation developed for this investigation by Counsel themselves.

> "I sought to keep proceedings as informal and inquisitorial as possible."

I am pleased that, for the most part, we achieved a non-adversarial approach throughout the inquiry. (To put the point more positively, it was an inquiry conducted by an Ombudsman in a manner consonant with an Ombudsman's approach to dispute resolution.) I am particularly proud of the conduct of the hearings themselves in this respect.

I also reported last year that I was about to start work on a second Article 2-compliant investigation, relating to the treatment of a young woman (SP) while in prison during 2003 to 2005. SP repeatedly self-harmed to the extent that her debilitated condition became life threatening.

What I wrote a year ago proved to be premature. Because of continuing discussions between SP's representatives and the Prison Service, I was unable actually to start work on the inquiry until the end of the year. Progress since then has been regrettably slow, partly due to staffing shortages within my office.

In light of my experience with Mr D, I am endeavouring to simplify the procedures significantly. In particular, I hope to keep the process as non-legalistic as possible. However, in order to ensure fairness and transparency, it appears to be necessary for me to consult with the various interested parties (and there are three in this case) at every stage of the investigation. I have no doubt, therefore, that this inquiry too will be protracted.

Nevertheless, I am approaching the SP inquiry as one of the most important pieces of work I have been asked to carry out in public service. The levels of self-harm, particularly amongst women in custody, are horrifying – both for the staff who must respond to each incident and for what they say about the distress suffered by many prisoners. I shall be doing my utmost to identify any lessons and to share them with the Prison Service and others.

FOR THE RECORD

In this section I provide statistical information about the complaints and fatal incidents investigated during the year, together with the costs of my office.

During 2007–08, the overall number of complaints remained steady at 4,750, just 71 more than in the previous year. There was a slight decrease in complaints about the Prison Service (a total of 4,231 of which 1,533 were eligible), but complaints about the Probation Service rose to 426 (37 eligible). In total, 4,601 complaints were from men and 149 (3 per cent) from women.

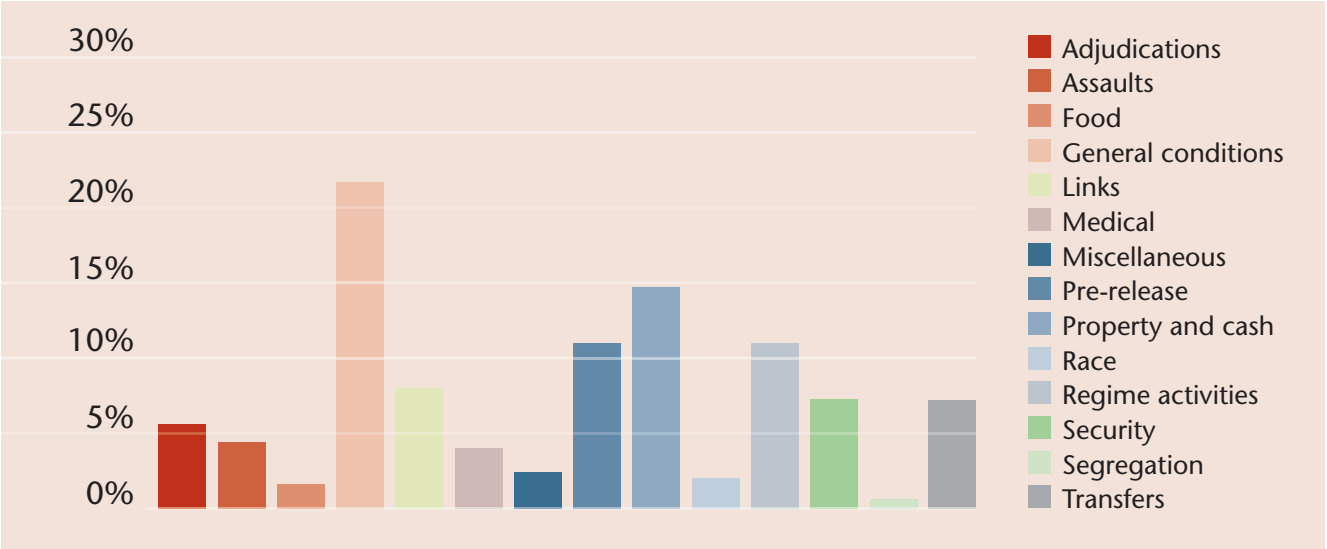
I received 93 complaints from detainees in Immigration Removal Centres (IRCs) of which just over 50 per cent (49) were eligible for investigation. This exceeded what might have been expected during the first full year for such investigations. I received complaints from across the removal estate ranging from three complaints at one establishment to 38 at another.

My office completed investigations into 1,673 complaints. Of these 1,594 were about the Prison Service, 38 about the Probation Service and 41 about Immigration Removal Centres.

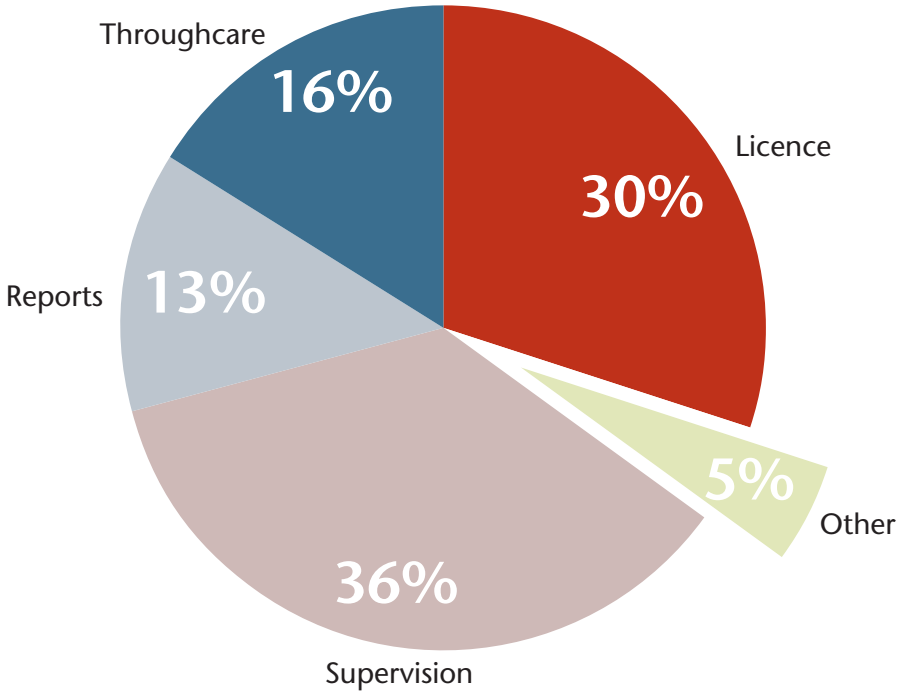
The overall uphold rate of complaints rose to 26 per cent, an increase of 3 per cent on 2006–07. The uphold rate for complaints about the Probation Service rose to 32 per cent, an increase of 5 per cent. In addition, 132 complaints were resolved by means of mediated settlements.

The following charts indicate the most common categories of complaints received.

Prison complaints received by category



Probation complaints received by category



Complaints performance

I regret that the backlog of work carried forward from the last reporting year has continued to impact upon my office's ability to meet a range of targets. In particular, complainants have had to wait far longer for the results of my investigations than I would wish. However, in the third quarter of the year I took steps to increase resources on a temporary basis with the result that our backlogs have been greatly reduced and I am far more optimistic about meeting targets in 2008–09. Among the work we have set in train for 2008–09 is the development of a more sophisticated and comprehensive performance framework.

Fatal incidents

The number of apparently self-inflicted deaths in custody fell significantly during the first three years after I took on responsibility for such investigations in April 2004. Sadly, during 2007–08, the number of apparently self-inflicted deaths rose from 73 to 83. Taking all services in remit, the number of apparently self-inflicted deaths grew from 76 to 92, an increase of 21 per cent. The total number of deaths (from all causes) that I investigated rose from 186 last year to 204, an increase of 10 per cent. Of those who died, 183 were prisoners, two had been recently released from prison (and the deaths thus came within my discretionary

remit), and 17 were resident in Probation Service Approved Premises. Two deaths occurred at Court. No one died in immigration detention.

The table below provides details of the 204 deaths on which investigations were opened.

Location and apparent cause of death

	Male Prisons	Female Prisons and YOIs	Male Young Offender Institutions	Approved Premises	Court Premises	Immigration Removal Centres	Discretionary Investigations
Self-inflicted	70	6	7	6	1	0	2
Natural causes	95	0	1	9	0	0	0
Homicide	1	0	0	0	0	0	0
Substance misuse	0	0	0	2	0	0	0
Unclassified	1	2	0	0	1	0	0
Total	167	8	8	17	2	0	2

Value for money

The office cost £7.3 million (including capital expenditure of £0.4 million) this year. Of the total, around £5.2 million represented the office's budget and £2.1 million was the notional share of Home Office/ Ministry of Justice central costs. The table opposite provides the full details.

	£
Staffing costs (salaries)	4,114,673
Non-pay running costs[6]	696,740
Share of departmental overhead[7]	2,119,875
Capital	404,359
Total	7,335,647

[6]Includes elements for depreciation and cost of capital, which were not charged during 2007–08 but will be applied retrospectively.
[7]Based on the 2006–07 figure inflated by 2% as the official Ministry of Justice figure was unavailable at the time of publication.

MISSION STATEMENT

Within one united office, to deliver two services that contribute to just and humane penal and immigration detention systems:

- To provide prisoners, those under community supervision and those in immigration detention with an accessible, independent and effective means to resolve their complaints.
- To provide bereaved relatives, the Prison Service, National Probation Service, UK Border Agency and the public at large with timely, high-quality investigations of deaths in prison custody and other deaths in remit.

STATEMENT OF VALUES

- To be accessible to all who are entitled to make use of the Prisons and Probation Ombudsman and actively to seek removal of any impediment to it.
- To be independent and to demonstrate the highest standards of impartiality, objectivity, thoroughness, fairness and accuracy in the investigation, consideration and resolution of complaints, and in the investigation of deaths in custody and other deaths in remit.
- To be sensitive to the needs of bereaved relatives providing explanations and insights, and ensuring that information from investigations is shared.
- To be fair in the treatment of all complainants, relatives and witnesses, without regard to criminal history, race, ethnicity, gender, disability, sexual orientation, age, religion, or any other irrelevant consideration.
- To be effective by ensuring that both complaints and fatal incident investigations are conducted thoroughly and as quickly as possible, and that recommendations are well founded, capable of being implemented and are followed through.
- To be constructive in helping the Prison Service, the National Probation Service and the UK Border Agency to deliver justice and decency by improving their handling of complaints and eliminating the underlying causes of them, and to assist the three services to reduce the incidence of avoidable deaths.
- To be empowering by creating and maintaining a working environment in which colleagues are respected, engage in continuous learning, obtain job satisfaction and have equal opportunities for personal and career development.
- To be accountable to stakeholders for the fulfilment of our mission statement, our values and aims and objectives.
- To be efficient in the management of resources and deliver full value for money.

TERMS OF REFERENCE

Complaints

1. The Prisons and Probation Ombudsman, who is appointed by the Secretary of State for Justice, is independent of the Prison Service and the National Probation Service for England and Wales (the NPS) and reports to the Secretary of State for Justice.

2. The Ombudsman will investigate complaints submitted by the following categories of person:[8]

   - individual prisoners who have failed to obtain satisfaction from the Prison Service complaints system and who are eligible in other respects; and

   - individuals who are, or have been, under the supervision of the NPS or housed in NPS accommodation or who have had pre-sentence reports prepared on them by the NPS and who have failed to obtain satisfaction from the NPS complaints system and who are eligible in other respects.

3. The Ombudsman will normally act on the basis only of eligible complaints from those individuals described in paragraph 2 and not on those from other individuals or organisations.

4. The Ombudsman will be able to consider the merits of matters complained of as well as the procedures involved.

5. The Ombudsman will be able to investigate:

   - decisions relating to individual prisoners taken by Prison Service staff, people acting as agents of the Prison Service, other people working in prisons and members of the Independent Monitoring Board, with the exception of decisions involving the clinical judgement of doctors and those excluded by paragraph 6. The Ombudsman's Terms of Reference thus include contracted-out prisons, contracted-out services and the actions of people working in prisons but not employed by the Prison Service; and

   - decisions relating to individuals described in paragraph 2 taken by NPS staff or by people acting as agents of area boards in the performance of their statutory functions, including contractors, and not excluded by paragraph 6.

[8]Complaints from those in immigration detention came within remit from 1 October 2006. This was formalised in a letter I received from the Minister of State for Immigration and Asylum on 28 November 2006, although my Terms of Reference have yet to be amended and updated. Work towards a comprehensive revision of my Terms of Reference was postponed following the announcement of the Government's intention to introduce legislation for the PPO office. As I have indicated in the foreword to this Report, if the legislation is not to be reinstated then revision of the non-statutory Terms of Reference is now long overdue.

6. The Terms of Reference do not cover:

   - policy decisions taken by a Minister and the official advice to Ministers upon which such decisions are based;
   - the merits of decisions taken by Ministers, save in cases which have been approved by Ministers for consideration;[9]
   - the personal exercise by Ministers of their function in the setting and review of tariff and the release of mandatory life sentenced prisoners;[10] or
   - actions and decisions outside the responsibility of the Prison Service and the NPS such as issues about conviction, sentence or immigration status; cases currently the subject of civil litigation or criminal proceedings; and the decisions and recommendations of outside bodies, including the judiciary, the police, the Crown Prosecution Service, the Parole Board and its Secretariat.

Submitting complaints and time limits

7. Before putting a grievance to the Ombudsman, a complainant must first seek redress through appropriate use of the Prison Service and NPS complaints procedures. 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.

8. The Ombudsman will consider complaints for possible investigation if the complainant is dissatisfied with the reply from the Prison Service or the NPS area board or receives no final reply within six weeks (in the case of the Prison Service) or 45 working days (in the case of the NPS).

9. Complainants submitting their case to the Ombudsman must do so within one calendar month of receiving a substantive reply from the Prison Service or, in the case of the NPS, the area board. However, 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 either of the Services.

10. Complaints submitted after these deadlines will not normally be eligible. However, the Ombudsman has discretion to consider those where there is good reason for the delay, or where the issues raised are so serious as to override the time factor.

[9]A personal Ministerial decision is one where the Minister makes a decision, either in writing or orally, following the receipt of official advice or signs off a letter drafted for their signature.
[10]These functions no longer exist.

Determining eligibility of a complaint

11. The Ombudsman will examine complaints to consider whether they are eligible. To assist in this process, where there is some doubt or dispute as to the eligibility of a complaint, the Ombudsman will inform the Prison Service or the NPS area board of the nature of the complaint and, where necessary, the Prison Service or area board will then provide the Ombudsman with such documents or other information as the Ombudsman considers are relevant to considering eligibility.

12. The Ombudsman may decide not to accept a complaint or to discontinue any investigation where it is considered that no worthwhile outcome can be achieved or the complaint raises no substantial issue. The Ombudsman is also free not to accept for investigation more than one complaint from a complainant at any one time unless the matters raised are serious or urgent.

Access to documents for the investigation

13. The Director General of the Prison Service and the National Director of the NPS will ensure that the Ombudsman has unfettered access to the relevant service's documents. This will include classified material and information entrusted to that service by other organisations, provided this is solely for the purpose of investigations within the Ombudsman's Terms of Reference and subject to the safeguards referred to in paragraph 16 below for the withholding of information from the complainant and public in some circumstances.

Local settlement

14. It will be open to the Ombudsman in the course of investigation of a complaint to seek to resolve the matter by local settlement.

Visits and interviews

15. In conducting an investigation the Ombudsman and staff will be entitled to visit Prison Service or NPS establishments, after making arrangements in advance, for the purpose of interviewing the complainant, employees and other individuals, and for pursuing other relevant inquiries in connection with investigations within the Ombudsman's Terms of Reference and subject to the safeguards in paragraph 16 below.

Disclosure of sensitive information

16. In accordance with the practice applying throughout 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.

Such circumstances will arise when disclosure is:

- against the interests of national security;
- likely to prejudice security measures designed to prevent the escape of particular prisoners or classes of prisoner;
- likely to put at risk a third-party source of information;
- likely to be detrimental on medical or psychiatric grounds to the mental or physical health of a prisoner or anyone described in paragraph 2 of these Terms of Reference;
- likely to prejudice the administration of justice, including legal proceedings; or
- of papers capable of attracting legal professional privilege.

17. Prison Service and NPS staff providing information should identify any information that they consider needs to be withheld on any of the above named grounds with a further check undertaken by the relevant service on receipt of the draft report from the Ombudsman.

Draft investigation reports

18. Before issuing a final report on an investigation, the Ombudsman will send a draft to the Director General of the Prison Service or to the National Director of the NPS depending on which service the complaint has been made against, to allow that service to draw attention to points of factual inaccuracy, to confidential or sensitive material which it considers ought not to be disclosed, and to allow any identifiable staff subject to criticism an opportunity to make representations.

Recommendations by the Ombudsman

19. Following an investigation, all recommendations will be made to the Secretary of State for Justice, or to the Director General of the Prison Service or to the National Director of the NPS or to the chair of the area board as appropriate to their roles, duties and powers.

Final reports and responses to complaints

20. The Ombudsman will reply to all those whose complaints have been investigated, sending copies to the relevant service and making any recommendations at the same time. The Ombudsman will also inform complainants of the response to any recommendations made.

21. The Ombudsman has a target date to give a substantive reply to the complainant within 12 weeks from accepting the complaint as eligible. Progress reports will be given if this is not possible.

Prison Service and NPS response to recommendations

22. The Prison Service and the NPS have a target of four weeks to reply to recommendations from the Ombudsman. The Ombudsman should be informed of the reasons for delay when it occurs.

Annual Report

23. The Ombudsman will submit an Annual Report to the Secretary of State for Justice, which the Secretary of State for Justice will lay before Parliament. The report will include:

    - a summary of the number of complaints received and answered, the principal subjects and the office's success in meeting time targets;
    - examples of replies given in anonymous form and examples of recommendations made and of responses;
    - any issues of more general significance arising from individual complaints on which the Ombudsman has approached the Prison Service or the NPS; and
    - a summary of the costs of the office.

Fatal incidents

1. The Ombudsman will investigate the circumstances of the deaths of the following categories of person:

    - prisoners (including persons held in young offender institutions). This includes persons temporarily absent from the establishment but still in custody (for example, under escort, at court or in hospital). It excludes persons released from custody, whether temporarily or permanently. However, the Ombudsman will have discretion to investigate, to the extent appropriate, cases that raise issues about the care provided by the prison;[11]
    - residents of NPS Approved Premises (including voluntary residents); and
    - residents of immigration detention accommodation and persons under Immigration Service-managed escort.

2. The Ombudsman will act on notification of a death from the relevant service. The Ombudsman will decide on the extent of investigation required depending on the circumstances of the death. For the purposes of the investigation, the Ombudsman's remit will include all relevant matters for which the Prison Service, the NPS (including area boards) and the Immigration Service are responsible, or would be responsible if not contracted for elsewhere by the Secretary of State for Justice or area boards. It will therefore include services

[11]Further to a second letter from the Minister for Immigration and Asylum, also dated 28 November 2006, this discretionary power also applies following a person's release from immigration detention.

commissioned by the Secretary of State for Justice from outside the public sector.

3. The aims of the Ombudsman's investigation will be to:

   - establish the circumstances and events surrounding the death, especially as regards management of the individual by the relevant Service or Services, but including relevant outside factors;
   - examine whether any change in operational methods, policy, practice or management arrangements would help prevent a recurrence;
   - in conjunction with the NHS where appropriate, examine relevant health issues and assess clinical care;
   - provide explanations and insight for the bereaved relatives; and
   - assist the Coroner's inquest in achieving fulfilment of the investigative obligation arising under Article 2 of the European Convention on Human Rights, by ensuring 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 learned.

4. Within that framework, the Ombudsman will set Terms of Reference for each investigation, which may vary according to the circumstances of the case, and may include other deaths of the categories of person specified in paragraph 1 where a common factor is suggested.

Clinical issues

5. The Ombudsman will be responsible for investigating clinical issues relevant to the death where the healthcare services were commissioned by the Prison Service (until March 2006), by a contractually managed prison or by IND.[12] The Ombudsman will obtain clinical advice as necessary, and will make efforts to involve the local PCT (in Wales, the Local Health Board) in the investigation. Where the healthcare services were commissioned by the NHS, the NHS will have the lead responsibility for investigating clinical issues under its existing procedures. The Ombudsman will ensure as far as possible that the Ombudsman's investigation dovetails with that of the NHS.

Other investigations

6. Investigation by the police will take precedence over the Ombudsman's investigation. If at any time subsequently the

[12]As the reference to March 2006 suggests, the first part of this sentence is now otiose. IND should be read to mean the Border and Immigration Agency during 2007–08 (now UK Border Agency).

Ombudsman forms the view that a criminal investigation should be undertaken, the Ombudsman will alert the police. If at any time the Ombudsman forms the view that a disciplinary investigation should be undertaken by the relevant Service, the Ombudsman will alert the relevant Service. If at any time findings emerge from the Ombudsman's investigation that the Ombudsman considers require immediate action by the relevant Service, the Ombudsman will alert the relevant Service to those findings.

7. The Ombudsman and the Inspectorates of Prisons and Probation will work together to ensure that relevant knowledge and expertise are shared, especially in relation to conditions for prisoners and detainees generally and judgements about professional probation issues.

Disclosure of information

8. Information obtained will be disclosed to the extent necessary to fulfil the aims of the investigation and report, including any follow-up of recommendations, unless the Ombudsman considers that it would be unlawful, or that on balance it would be against the public interest to disclose particular information (for example, in exceptional circumstances of the kind listed in paragraph 16 of the Terms of Reference for complaints). For that purpose, the Ombudsman will be able to share information with specialist advisers and with other investigating bodies, such as the NHS and social services. Before the inquest, the Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Reports of investigations

9. The Ombudsman will produce a written report of each investigation which, following consultation with the Coroner where appropriate, the Ombudsman will send to the relevant Service, the Coroner, the family of the deceased and any other persons identified by the Coroner as properly interested persons. The report may include recommendations to the relevant Service and the responses to those recommendations.

10. The Ombudsman will send a draft of the report in advance to the relevant Service, to allow the Service to respond to recommendations and draw attention to any factual inaccuracies or omissions or material that they consider should not be disclosed, and to allow any identifiable staff subject to criticism an opportunity to make representations. The Ombudsman will have discretion to send a draft of the report, in whole or part, in advance to any of the other parties referred to in paragraph 9.

Review of reports

11. The Ombudsman will be able to review the report of an investigation, make further enquiries, and issue a further report and recommendations if the Ombudsman considers it necessary to do so in the light of subsequent information or representations, in particular following the inquest. The Ombudsman will send a proposed published report to the parties referred to in paragraph 9, the relevant Inspectorate and the Secretary of State for Justice (or appropriate representative). If the proposed published report is to be issued before the inquest, the Ombudsman will seek the consent of the Coroner to do so. The Ombudsman will liaise with the police regarding any ongoing criminal investigation.

Publication of reports

12. Taking into account any views of the recipients of the proposed published report regarding publication, and the legal position on data protection and privacy laws, the Ombudsman will publish the report on the Ombudsman's website.

Follow-up of recommendations

13. The relevant Service will provide the Ombudsman with a response indicating the steps to be taken by the Service within set timeframes to deal with the Ombudsman's recommendations. Where that response has not been included in the Ombudsman's report, the Ombudsman may, after consulting the Service as to its suitability, append it to the report at any stage.

Annual, other and special reports

14. The Ombudsman may present selected summaries from the year's reports in the Ombudsman's Annual Report to the Secretary of State for Justice, which the Secretary of State for Justice will lay before Parliament. The Ombudsman may also publish material from published reports in other reports.

15. If the Ombudsman considers that the public interest so requires, the Ombudsman may make a special report to the Secretary of State for Justice, which the Secretary of State will lay before Parliament.

MEMBERS OF THE PPO OFFICE 2007–08

Ombudsman

Stephen Shaw CBE

Senior Personal Secretary

Jennifer Buck

Deputy Ombudsmen

Emma Bradley (*to November 2007*)
Rhian Evans
Tony Hall
Jane Webb

Acting Deputy Ombudsmen

David Barnes
Ali McMurray

Personal Secretary

Janet Jenkins

Assistant Ombudsmen

Louise Baker
Lucy Eames (*to March 2008*)
Marian Morris
Gordon Morrison
Olivia Morrison-Lyons
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Head of HR & Business Development

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Karen Chin
Steve Clarke
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James Crean
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Rob Del-Greco
Kate Eves (*to November 2007*)
Angie Folkes
Ann Gilbert
Kevin Gilzean
Alan Green
Natasha Griffiths
Helena Hanson
Michael Hegarty (*to May 2007*)
Diane Henderson
Denise Hotham
Ruth Houston
Sarah Hughes
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Karen Jewiss
Mark Judd
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Madeleine Kuevi
Lisa Lambert
Anne Lund
Steve Lusted
Kirsty Masterton
Lisa McIlfatrick
Steven McKenzie
Beverly McKenzie-Gayle
Tracey Mulholland
Anita Mulinder
Peter Nottage
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Amanda O'Dwyer
Ben Rigby
James Rogerson (*to October 2007*)
Anna Siraut
Amanda Steyn
Kevin Stroud
Rick Sturgeon
Anne Tanner
Dorne Thompson (*to March 2008*)
Steve Toyne
Ian Truffet
John Unwin
Thea Walton
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Bryan Woodward
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Demelza Penberth

Family Liaison Officers

Abbe Dixon
Jennifer Howse
Laura Stevenson

Information Manager

John Maggi

Assistant Information Manager

Jay Mehta

Office Manager

Geoff Hubbard

Finance Officer

Mark Chawner

Requisitions Officer

Samantha Torrington

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Tracy Wright

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David Kent
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