Prisons & Probation Ombudsman
Independent Investigations

Annual Report 2019/20

CP 301

Prisons & Probation Ombudsman

Annual Report 2019/20

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

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CP 301

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

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

020 7633 4100
mail@ppo.gov.uk

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Contents

The role and function of the PPO

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

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

The PPO has three main investigative duties:

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

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

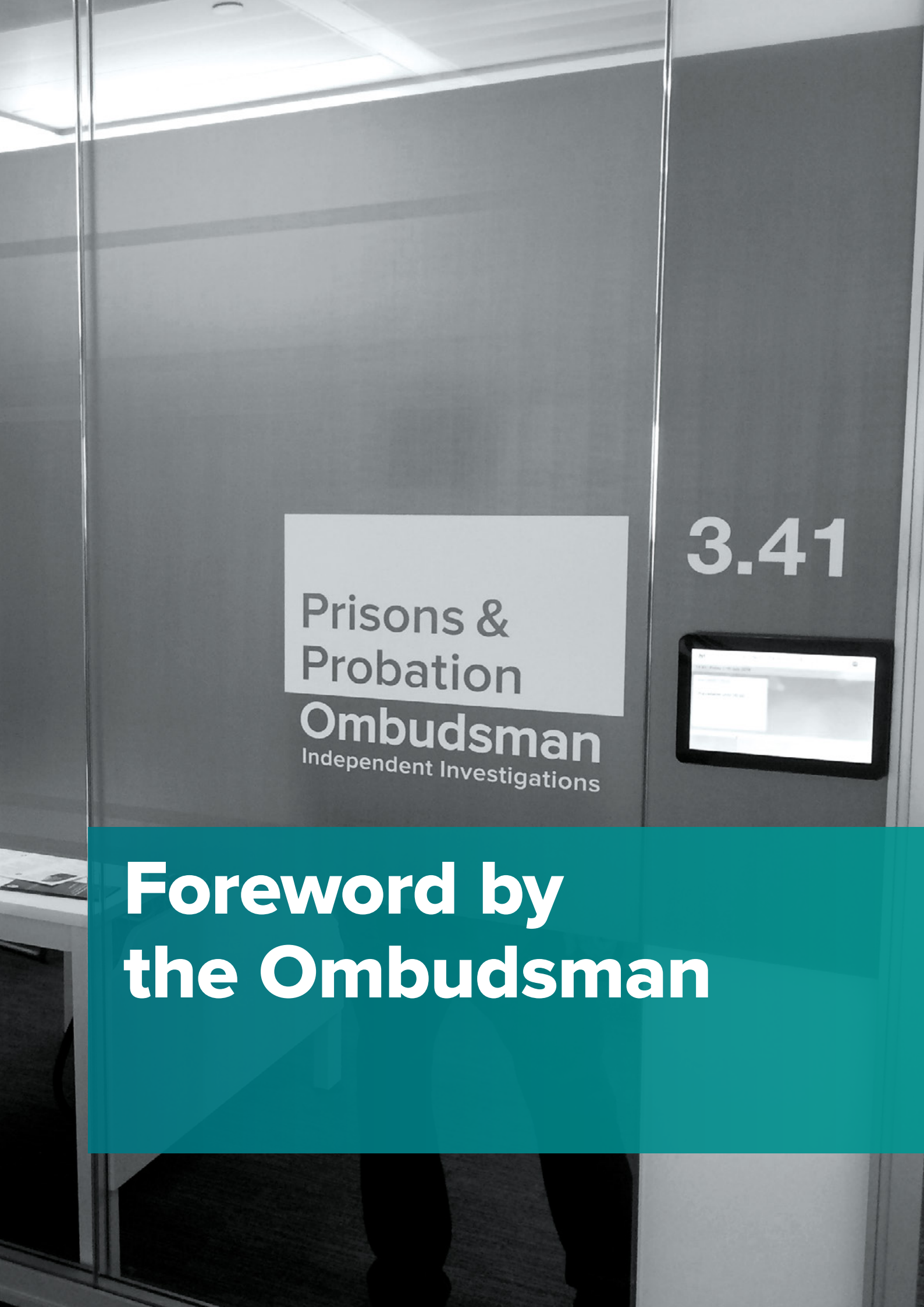
Our vision

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

Our values

We are:

Impartial: we do not take sides
Respectful: we are considerate and courteous
Inclusive: we value diversity
Dedicated: we are determined and focused
Fair: we are honest and act with integrity



Foreword by the Ombudsman

The year covered by this annual report has been another in which demand for our services has remained high, although there were small, but welcome, falls in both the number of complaints we received and the number of deaths into which we started investigations. We received 4,686 complaints in 2019/20, 6% fewer than the 4,968 in the previous year. We started investigations into 311 deaths, a 7% reduction from 2018/19, when the figure was 334. This figure represented small reductions across all categories of deaths, including a 7% decrease in the number of those that were self-inflicted, from 89 in 2018/19 to 83 this year. There were 31 other non-natural deaths, a decrease of 27 deaths compared to last year[2] and there were still 19 deaths awaiting classification.

In March 2020, the imposition of the national lockdown in response to the COVID-19 global pandemic brought significant changes to how we were able to work. We were not able to access our offices and all our staff had to work from home. We had to be innovative about how we maintained our services.

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Improving confidence in the PPO also meant working to strengthen the knowledge and understanding our partners and stakeholders have of the PPO and what we do.

Our annual report next year will reflect how we have worked under the restrictions and, we hope, our business recovery as we returned to more normal working arrangements.

Through the year, we maintained our focus on the key themes outlined in our Strategic Plan for 2019-2021:

- **confidence**
- **effectiveness**
- **impact**
- **efficiency**

2 Please see the About the data section for further details about other non-natural cause deaths.

Improving confidence in the PPO also meant working to strengthen the knowledge and understanding our partners and stakeholders have of the PPO and what we do. This included the people who can complain to us, the staff who work in the services in remit and those in other organisations. I, and PPO colleagues, accepted invitations to speak at conferences, meetings and other events to talk about our work and we undertook a programme of regular visits to prisons where we sat down with groups of prisoners to tell them about the PPO and to listen to their views, suggestions and criticisms on how we work and how we could improve. We were also able to use the Prison Reform Trust's Prisoner Policy Network to get feedback on our complaints handling from some of those with first-hand experience.

Our focus on effectiveness and impact included looking at the recommendations we make, particularly in our fatal incident investigation reports, to make sure they are focused on outcomes that will contribute to safer, more decent prisons and other places of detention. We remain frustrated at the number of repeat recommendations we have to make, sometimes where changes have been promised (in an action plan from the prison or from HMPPS HQ) but not delivered. In our efforts to better understand the barriers to the implementation of our recommendations, we have been working with one of our academic partners to develop options for trialling different ways of reporting what we find and how we make recommendations.

We were pleased to strengthen the collective skills and experience of our staff group when we welcomed two new colleagues, both of whom had been recently released from prison. The inclusion of people with lived experience of prison will make us more effective and we will continue to identify ways to recruit people from underrepresented groups into our team.

The introduction of new policies and ways of working in HMPPS has been reflected in some complaints we received and in what we have found in the course of our investigations. We received the first complaint about the use of Pelargonic Acid Vanillylamide (PAVA) incapacitant spray and found, in our investigation, that PAVA had not been used in accordance with the requirements of the policy. We note that the provision of PAVA has now been extended to all adult male closed prisons, although training more staff in its use has been paused. We are concerned by this decision to roll out PAVA without the previously agreed preconditions of an effective key worker scheme and the need for at least 50% of staff to be trained in its use before it is issued in a prison. We will monitor carefully any complaints we receive about PAVA in the future.

It was frustrating that, for another year, the most common category of the complaints we received was property that had been lost or damaged in prison, or in transit from one prison to another, or was not allowed. Items of personal property are hugely important to prisoners and some, such as photographs or religious items, are irreplaceable. We continue to receive assurances from HMPPS that they are making improvements to their arrangements for handling property but it has taken far too long and the much needed improvements are long overdue.

In our fatal incident investigations, we found that healthcare in some prisons did not meet the required standard and was not equivalent to that in the community. In some cases, the provision of healthcare was very poor and failed to meet the physical and mental health needs of patients. Whilst we found examples of good practice in some of the cases we investigated, in others we found that staff were not adequately trained, that there were not enough staff to carry out essential tasks or, in some cases, that healthcare professionals failed in their duty of care to patients. We also found that complex commissioning and delivery arrangements for prison healthcare sometimes caused delays to care, or a failure to deliver care, for example to patients with dementia.

For another year, our investigations into some drug related deaths in probation approved premises (APs) have led us to recommend that the National Probation Service should review its drugs strategy, particularly that AP staff should be able to test for psychoactive substances (PS) and have access to opioid antidotes. The most recent commitment from the NPS is that they aim to roll out a revised strategy over the course of 2020. Whilst this is encouraging, we are concerned that the strategy has long been promised and we consider that urgent action is now needed to make sure the new deadline is met.

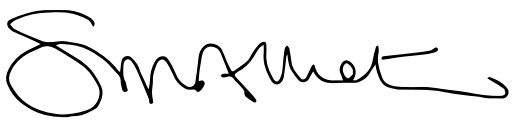
We know that HMPPS has revised parts of the ACCT process, as well as the forms and associated guidance. We hope that this will deliver the necessary improvements to the way prisoners are supported. We are disappointed that the roll out of the new ACCT has taken so long and is now paused, along with the rest of the safety programme, due to the COVID-19 pandemic.

We have recognised that, to manage the high number of fatal incident investigations we carry out, and to direct our finite resources where they can have most impact, we need to be more agile and proportionate in the way we investigate, and report on, the deaths of some people from natural causes, particularly where those deaths are foreseeable. A six month pilot, where the investigation focused on the clinical review and the PPO investigator considered a small number of non-clinical areas, was conducted this year and we will consider the impact of having a shorter, lighter touch investigation before we decide whether to adopt this new methodology and, potentially, use it in other cases where we consider it to be appropriate.

We continue to be asked to carry out investigations outside of our Terms of Reference and, in September 2019, we were asked to conduct an overarching investigation into the death of a baby born to a woman in prison. That investigation is not yet complete and has required our investigator to work closely with other agencies who had been involved in the care of the baby's mother both within, and beyond, the criminal justice system. In November 2019, our investigation into allegations of misconduct against staff at Brook House Immigration Removal Centre was converted to a statutory inquiry. As PPO, I recused myself as chair of the inquiry and an independent chair was appointed.

Alongside our complaints and fatal incidents teams, where our investigations are carried out, our Learning Lessons and Strategic Support team has continued to provide the essential services necessary to support our organisation, including the thematic work we do to identify lessons from the collective analysis of our work and share it with our stakeholders. We have strengthened the ways we communicate with all those with an interest in our work. The restrictions of COVID-19 have driven us to find more creative ways to do this. We now use the Email a Prisoner (EMAP) service for some non-sensitive letters to prisoners and we have broadcast to people in prison via prison radio and in-cell television to keep them updated on the changes to how we are working during the lockdown. We are making changes to our PPO website to make it more accessible and more useful to those who tell us that they use it. We will evaluate the impact of these new methods and may decide to continue to use them if they are shown to be effective.

I want to thank my colleagues, across all the PPO functions, for continuing to work with professionalism and resilience through a challenging time, and for their significant contributions throughout the rest of the year.



Sue McAllister CB
Ombudsman

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The year in figures

Complaints

In 2019/20 we received **4,686 complaints**, a 6% decrease compared to last year. Of these:

- **the most common complaint category was property (28%)** – staff behaviour (8%) and administration (8%) were the next most common categories
- **23 were about immigration removal centres**, 16 fewer than last year
- **294 were about probation services**, 13 more than last year

We sent **5,604 eligibility letters** to complainants in 2019/20.[3]

In 2019/20 we **started investigations into 2,203 cases** compared to 2,584 in 2018/19, a decrease of 15%, this followed a 4% increase in the previous year.

We completed **2,450 investigations** this year.[4] Of these:

- **34% came from the long term and high security estate** (which makes up 11% of the prison population) – 28% of complaints from prisoners in the long term and high security estate were upheld compared to 34% of complaints from other prisoners
- **31% of cases were found in favour of the complainant**, which was similar to last year (32%)

We do not investigate eligible cases if, for example, the complaint does not raise a substantive issue or if there is no worthwhile outcome. This helps us to appropriately allocate our resources. Of the cases we closed in 2019/20:

- **285 complaints were declined for investigation**, 23 more than last year
- **115 complaints were withdrawn this year** – this includes complaints withdrawn by the PPO and by the complainants themselves

3 The number of eligibility letters sent in 2019/20 refers to letters of eligibility that the PPO sent to complainants in both eligible and ineligible cases. We have not been able to calculate how many of these were on time due to moving over to a new case management system. We are continuing to explore ways to collect this data in the future. Please see the About the data section for what is an eligible, upheld and not upheld case.

4 A completed case in 2019/20 is defined as when the draft outcome has been approved. In previous years, we defined a completed case as when a final outcome was sent. For this reason, the figures produced this year are not comparable to previous years. We have not been able to calculate how many completed cases were completed on time due to moving over to a new case management system and the change in definition. We are continuing to explore ways to collect this data in the future.

Fatal incidents

In 2019/20, we started investigations into **311 deaths**, a 7% decrease compared to last year. The majority of these deaths were of prisoners (93%). We began investigations into:

- **176 deaths from natural causes**, 1 fewer than last year
- **83 self-inflicted deaths**, a 7% decrease from last year
- **2 apparent homicides**, 2 fewer than last year
- **31 other non-natural deaths**, a decrease of 27 deaths compared to last year. However, it is important to note that, at the time of writing, there were still 19 deaths awaiting classification
- **17 deaths of residents living in probation approved premises**, 5 more than last year
- **1 death of a resident of the immigration removal estate**, equal to last year
- **3 discretionary cases** – the death of an individual who died shortly after attempting suicide in a court cell, the death of a prisoner who was appearing for sentence in court and an apparent stillbirth in a prison[5]

Fortunately, this year we began **no investigations of fatal incidents in secure children's homes**.

This year we issued **343 initial and 341 final reports** compared to 309 initial and 266 final reports last year.[6] In 2019/20:

- 80% of initial reports and 67% of final reports were issued on time
- the average time to produce an initial report for a natural cause death was 19 weeks and for all other deaths was 26 weeks

As of 31 March 2020, there were **544 fatal incident investigations** where we had not published the report on our website. This includes: investigations where we have not issued a final report and we are still investigating; cases where we have issued the final report, but we are awaiting notification that the coroner's inquest has concluded in order to publish the report; and a small number of reports waiting to be published.

1,050 recommendations made by PPO following deaths in custody related to (among other subjects):

- 312 healthcare provision
- 161 emergency response
- 90 substance misuse
- 89 suicide and self-harm prevention

5 We also investigated one post-release death, the case of Mr E, who was technically released from prison under Home Detention Curfew two days before his death, although he remained in hospital and was never released into the community.

6 These figures have been updated from last year's report due to an error.

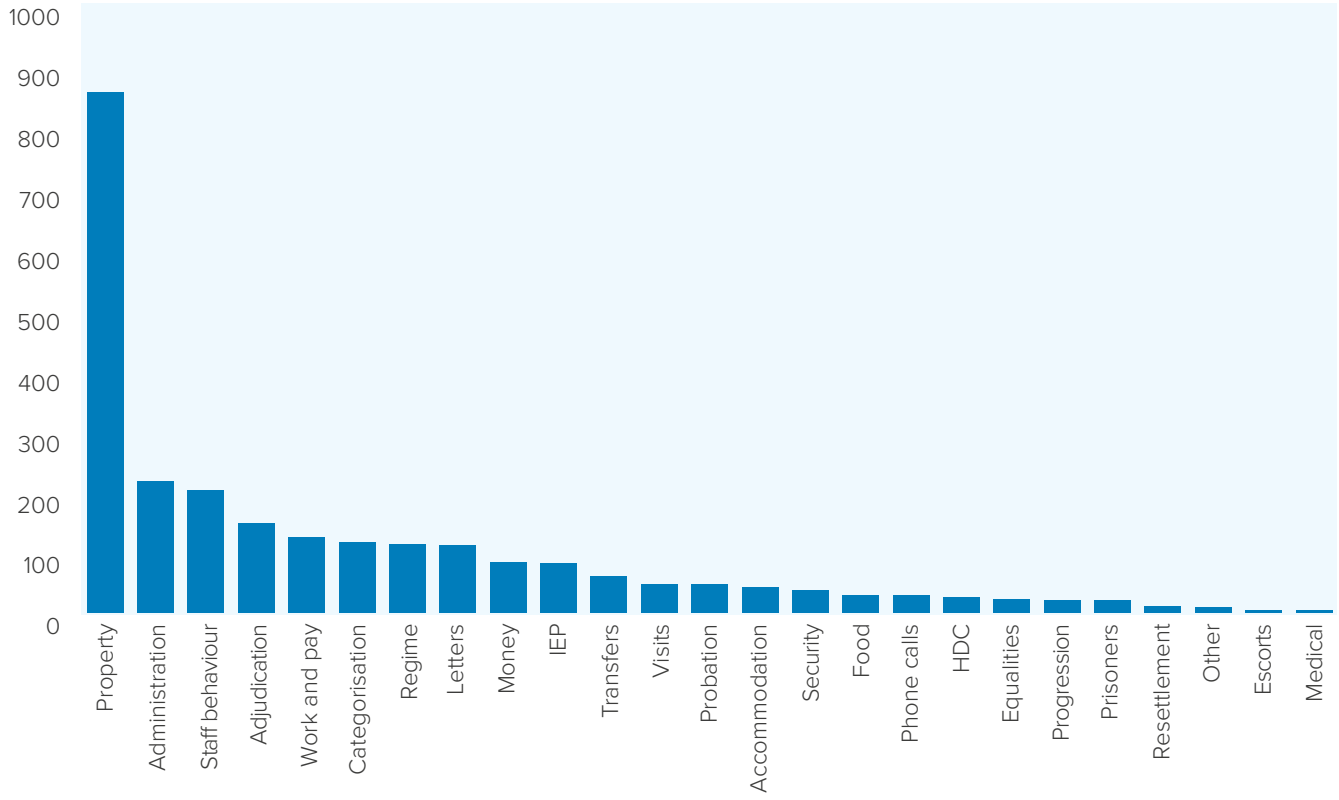
Complaints

4,686 **complaints**
6% decrease
compared to last year

2,450 **investigations completed** in 2019/20

31% were **found in favour** of the complainant

Complaints completed (2019/20)



Fatal Incidents

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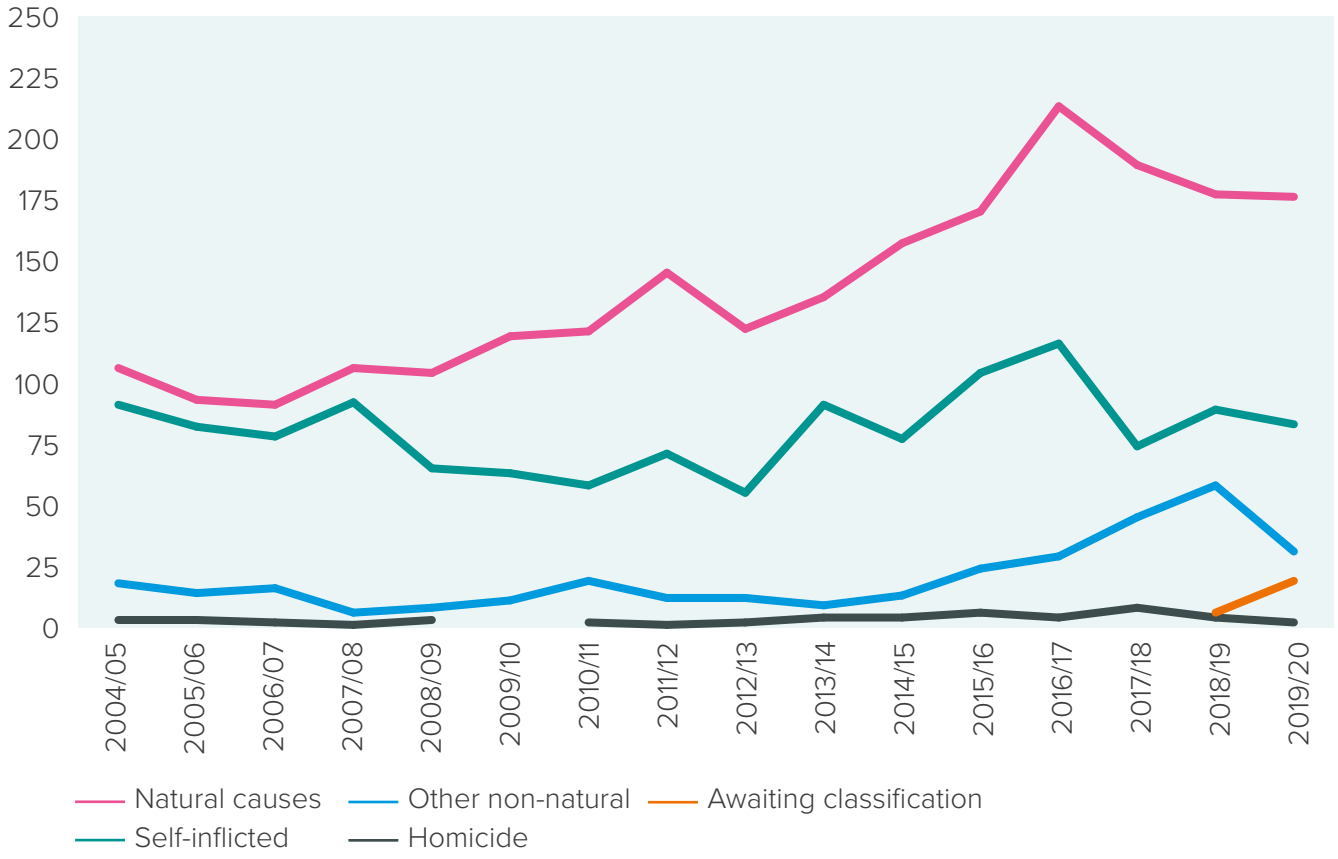
Fatal incidents investigated



Investigating complaints

This reporting year, we have focused our attention on ensuring that prisoners understand who we are, and what we do. It is vital that those who can complain to us have confidence in the service we provide and trust that we will carry out a robust, independent and high-quality investigation which will have an impact on the services in remit.

We were pleased to join colleagues from the Prison Reform Trust at some of their prisoner focus groups, discussing key issues affecting those in prison. What we heard during these groups, and sessions we had organised ourselves as part of our research project into prisoners' experiences of the complaints process, highlighted that there was much more we could do to raise our profile and help prisoners understand our role and processes. At the beginning of 2020, we began a programme of informal prisoner discussion groups, intending to hold at least 12 across the year at different prisons. Unfortunately, the COVID-19 pandemic and the national restrictions imposed in March meant that we had to pause the groups, but they are a PPO priority and we will restart them as soon as we are able to. The aim of the groups is not only to inform prisoners of our role, but also to listen to their thoughts about how we could improve the service we offer, and to make real changes to our processes.

We are committed to using a range of methods to communicate with prisoners and, this reporting year, we published several articles in Inside Time (the monthly newspaper for prisoners) and hope to continue to make regular contributions. At the end of the reporting year, we began working with Prison Radio Association (a national radio station for prisoners) and Wayout TV (who provide in-cell television). They worked with us to produce broadcast material to improve prisoners' knowledge of the PPO and explain some essential processes, including how to make an eligible complaint. We will report on the impact of these initiatives in next year's annual report.

We have made changes to how we manage the complaints we receive to ensure we are as efficient and effective as we can be. In 2019/20, we changed the process by which complaints are allocated for investigation. Complaints are now allocated to investigation teams according to the prison where the complaint originated. By making teams responsible for all the complaints from specific prisons (organised geographically and/or by prison function), we have increased our ability to spot trends and respond with agility to emerging issues, and improved liaison with prison governors and prison group directors (PGDs). We believe this will strengthen our impact and deliver improved outcomes and we will evaluate the effectiveness of these changes as part of our commitment to continuous improvement.

After a review, we decided to end our live telephone service and replace it with a voicemail service, monitored daily. We know that some prisoners, their family members and other stakeholders, appreciated being able to speak directly to PPO staff when they rang, but we need to make the best use of the staff we have in our complaints teams and we feel confident that the move to the voicemail service has made us more efficient in investigating the complaints we receive. We will continue to monitor the change to ensure it does not have unintended consequences for those who want to contact us.

As noted elsewhere, during this reporting year, the PPO moved to a new case management system. The challenges of migrating all of our data to this new system, mean it is not possible in all cases to compare figures about the work complaints staff have completed this year with the last. However, we do know that we received 6% fewer complaints in 2019/20, and we accepted for investigation 15% fewer cases than last year.

Last year, we reflected on the complexity of using the uphold rate as a measure of the quality of both initial HMPPS investigations and, subsequently, our own investigations. We continue to think about other, more effective measures to use. During the reporting year, we introduced a new internal quality assurance programme. At this early stage, the results are positive but we will continue to review the process to ensure it is robust and fit for purpose. This reporting year, we upheld 31% of the complaints we completed which was similar to last year (32%). Again, this does not include complaints that we did not uphold, but where we identified other issues and made recommendations.

This reporting year, we have continued to focus on the impact that our investigations have on the services in remit. The recommendations we make in our investigations are, clearly, a key mechanism for bringing about positive and necessary change. In 2019/20, we made 686 recommendations in 282 cases. In just under two thirds of recommendations, we have received a response from HMPPS, accepting our recommendations. We have received evidence that 80% of the recommendations HMPPS has accepted have been implemented. Only one of our recommendations was rejected.

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In 31% of recommendations, we recommended that the governor issue a notice to staff to remind or advise them of correct procedures. In 18% of recommendations (largely property complaints) we recommended the prison compensate the prisoner, and in 12% to apologise to the complainant. We do not underestimate the power of a well written, meaningful apology from a suitably senior member of staff.

As we expected, the majority of the complaints received and accepted for investigation came from adult male prisoners, and covered a range of topics.

Property

Once again, in 2019/20 the largest proportion of complaints we received were about property. These complaints amounted to 28% of all complaints we received (a small but welcome drop from last year). Of the property cases we completed this year, we upheld almost half of those we investigated (49%), which is the highest uphold rate across all complaint categories.

For some years now, we have commented in the annual report about our frustrations with how prisoners' property is often mishandled, and how the problems are compounded by poor complaint responses by prisons. This year, we focused attention on working with HMPPS to improve property handling policies and processes. We contributed to the ongoing review of the HMPPS property policies, sharing with HMPPS colleagues our expertise in identifying common problems in both property management and complaint responses. We met colleagues from the long term and high security estate (where 25% of completed property complaints were from 2019/20) to discuss the particular problems of property management in these prisons, and to identify potential solutions. We also conducted a year-long pilot study with the North Midlands prison group aimed at improving both the prisons' and the PPO's responses to property complaints. We are now reviewing the results to identify learning we can apply more widely.

In May 2019, we used the PPO online publication, The Investigator, to write about some common issues in property complaints. We set up a working group of investigators to consider some of the themes described in the article. The task now is to consider how best to implement some of the learning the group identified, including working with HMPPS to ensure that local responses to property complaints are appropriate and robust, and ensuring that prisoners understand the level of detail we need to investigate property complaints. Property is still a problem area, and we remain committed to improving outcomes for prisoners and prisons.

The following case study illustrates a common issue in property complaints: prisons relying on a disclaimer in the prison service instruction (PSI) which covers prisoners' property.

Mr A complained that he lost most of his property when he moved prison after a court appearance. He said that staff at the sending prison told him that he would return there after the court appearance, and so he did not take the property in his cell (known as in possession property) with him. He had still not received his property six months later, despite the sending prison telling him they had sent all of his belongings to the receiving prison. Mr A told us that his missing property was worth over £2,000. In their responses, the sending prison told Mr A that he had been advised to pack his belongings before his court appearance and had refused, and that they no longer had any of his possessions.

Our investigation established that, whether or not Mr A had been advised to pack his belongings, he had not and they had been left in his single cell when he did not return from court. The sending prison could not supply us with a Cell Clearance Certificate detailing what action they had taken to pack and store Mr A's belongings when he did not return, and relied on a disclaimer in the PSI concerning prisoners' property that in possession property is held at the prisoner's risk.

We were concerned that we had received several similar complaints about the sending prison. We considered that, although Mr A was initially responsible for packing his possessions before his court appearance, when he did not, the sending prison had failed in their responsibilities to secure and send on his property. We upheld his complaint and recommended that the sending prison compensate him for his missing possessions, apologise for mishandling his property and remind staff of their obligations under the PSI. The prison accepted the recommendations and provided evidence that they had been implemented.

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This year, we focused attention on working with HMPPS to improve property handling policies and processes.

Use of force

In 2019/20, we completed 201 investigations into complaints about staff behaviour, including complaints about the use of force and alleged assaults by prison staff. Last year, we noted that 2018 had seen a peak in the number of recorded assault incidents in prison;[7] this year the number has decreased slightly. However, in 2019 around a third of the recorded assault incidents involved violence by prisoners against prison staff.[8] In response, this year HMPPS introduced several safety measures, including rigid bar handcuffs and new personal protection training, to equip suitably trained staff with the skills to manage potentially violent situations.

The PPO maintains the position that the use of force should be available to staff as an option, but our investigations ensure that it is used in line with guidance, only when strictly necessary, and proportionate to the circumstances. Our scrutiny role in use-of-force incidents is all the more important with the introduction of new techniques and equipment.

Towards the end of the last reporting year, HMPPS also piloted the use of PAVA incapacitant spray. The accompanying guidance made clear that PAVA was not a replacement for the existing formal restraint techniques, but should be seen as a last resort to resolve a situation where there were no other options, or they had been exhausted.

The following PAVA complaint allowed us to test the guidance and consider how new techniques might be used in practice. As PAVA is rolled out across the prison estate, we will continue to monitor its use and governance.

7 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/797074/safety-custody-bulletin-q4-2018.pdf

8 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/893374/safety-in-custody-q4-2019.pdf

Mr B complained that, while being assaulted by another prisoner in a communal area, staff used disproportionate and unnecessary force against him when they struck him with a baton and used PAVA spray. Internal investigations concluded that the officers involved, some of whom were new and inexperienced, had acted appropriately to manage a difficult situation.

Our investigation found that staff had not managed the incident well. We concluded:

- PAVA was not used as a last resort. The officers involved did not try and resolve the incident using formal restraint techniques before using PAVA. The use of PAVA was therefore not justifiable in the circumstances.
- Mr B was the victim of an assault by another prisoner and so it was inappropriate to target Mr B with the PAVA spray.
- The techniques used by the officer who deployed PAVA did not comply with the HMPPS guidance.

We were also concerned about the lack of HMPPS oversight of the use of PAVA during the pilot phase of its introduction. We made a number of strategic recommendations to HMPPS concerning the governance for PAVA use, as well as local recommendations to the prison governor.

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Sometimes, we notice complaints about very specific aspects of prison life. One such area is complaints about alleged sexual assaults by staff during the full search process. The nature of the complaints we have received indicate that prisoners have a poor understanding of what a full search will look and, indeed, feel like. When the prison can provide a reasonable and evidenced justification for a full search, it is difficult for us to find a sexual intent after the fact. It is possible these complaints illustrate a lack of communication between the prison and prisoners and that providing a clear explanation of what a full search involves would avoid future complaints.

Mr C complained that during a full search, staff had physically and sexually assaulted him. Mr C agreed that he had resisted the full search and had refused to squat, so that staff could check for contraband hidden in his anus.

The relevant HMPPS guidance states that staff can conduct a full search, including requiring a prisoner to squat, on intelligence or where there is reasonable suspicion that an item has been concealed (staff may not conduct intimate searches of bodily orifices, but may conduct a visual inspection if they suspect something is hidden there). Staff reported that Mr C had indicated that he had hidden more than one mobile telephone internally (which Mr C denied) and so were justified conducting the full search.

We concluded that a full search was, by its nature, intrusive, embarrassing and uncomfortable, and could well be perceived as a sexual assault by a prisoner who had never undergone such a search before and who did not know what to expect.

We did not uphold Mr C's complaint but did identify other shortcomings related to the completion of the relevant paperwork (a disappointingly common finding in use-of-force investigations) and made several recommendations.

Administration

Complaints that we categorise as being about prison administration cover, as one might expect, a wide range of issues. In 2019/20, we completed 216 investigations into administrative issues.

Sometimes, the nature of the complaints we receive serves as a stark reminder that, while those of us in the community enjoy simple freedoms, the pace of change in prisons is very much slower – and this can cause tangible difficulties for prisoners, as demonstrated by the following case study.

Mr D's mother sent him a paper copy of an approved clothing supplier's catalogue. Prisoners are not allowed to receive magazines in the post because of the risk that the paper has been impregnated with drugs, and so staff confiscated the catalogue. Mr D complained that his mother had sent the catalogue to him because one had not been available on the wing for over a year and there was no other way for him to browse the selection and make an order.

Our investigation found that there was no way for Mr D to view the clothing brand's catalogue. None was available in the prison, and they had not made any provision to print a copy or allow prisoners to view the online catalogue.

To resolve Mr D's complaint, we arranged for the clothing brand to provide several copies of the catalogue to the prison. This resolved the immediate issue for Mr D and other prisoners at the prison, but not the wider point. We recognised that, in future, paper catalogues were likely to become obsolete and that HMPPS should take a proactive approach to address the issue. We made a national recommendation that HMPPS reviewed the current provision for prisoners to order items from approved suppliers in the absence of paper catalogues. HMPPS has yet to provide us with a detailed action plan in response to the recommendation.

Frustratingly, we still receive complaints about prisons' poor complaint handling. We have written about this issue in previous annual reports and it goes to the heart of why an independent complaints resolution body is so important.

Mr E complained that his allegation of staff discrimination on the basis of his disability had been responded to by one of the staff he had complained about. He also said that the prison's response to his complaint was very late and did not deal with the issues he had raised.

Our investigation found that the prison responded to Mr E's initial complaint nearly four months after he submitted the complaint, in breach of the relevant PSI. We also concluded that Mr E's complaint, which referenced his disability, should have been dealt with under the specific arrangements for responding to complaints that raised equalities issues, and was not, contrary to policy. Finally, we found that when Mr E submitted a Discrimination Incident Reporting Form (DIRF), his complaint was not investigated or responded to by a member of staff with sufficient seniority. We upheld Mr E's complaint and made a recommendation that the governor remind staff of the correct processes for handling complaints, particularly those involving equalities issues. We have not yet received evidence that the prison has implemented the recommendation.

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Categorisation

In 2019/20, we completed 116 complaints from prisoners about how decisions relating to their risk, and so which security category prison they should be held in, were made (known as categorisation). We only upheld 12% of these complaints, an indication of how tightly framed categorisation policies are. We understand why prisoners are keen to achieve a lower categorisation and enjoy the greater freedoms that come with this, but the complaints we receive often highlight the complex nature of risk-related decisions.

Mr F complained about being refused category D status and a move to an open prison. He was serving a six-year sentence for defaulting on a court Confiscation Order and, at the time of his complaint, owed over £2 million. The categorisation board noted that, while low risk in some ways, the amount of monies outstanding meant there was a risk that Mr F would try to leave the country to avoid paying the order.

Decisions to recategorise a prisoner are matters of judgement and the PPO will normally only uphold a complaint about categorisation if it is clear that the prison had not complied with the relevant HMPPS policy, had based the decision on flawed or incomplete information, or was so unreasonable in its decision-making as to render the decision unfair. The relevant PSI instructed that staff must take into account the amount of any outstanding confiscation orders and the subsequent risk of the prisoner absconding.

In this case, we concluded that the prison had applied the policy appropriately and the decision was reasonable. We did not uphold the complaint.

Long term prisoners

Of the cases we completed in 2019/20, 34% came from the long term and high security estate, which makes up 11% of the prison population. It is unsurprising that those serving long sentences of imprisonment have the time and motivation to complain. More often than not, the issues faced by these prisoners are the same as any other, but sometimes their complaints raise more unique questions related to their actual, or perceived, level of risk.

Mr G complained about the covert use of body worn video cameras (BWVC) in the close supervision centre (CSC) in which he was held at the time. Mr G provided details of three separate incidents when he believed staff had covertly recorded prisoners' conversations in the centre. The officer who responded said that, on both occasions, staff had felt tensions were heightened in the CSC and that an incident that risked the safety of prisoners or staff was about to occur. At appeal, a manager reiterated that the officers had correctly used their BWVC.

National policy makes it clear that the use of BWVC must always be overt, and that staff should tell prisoners when they are activating the camera. It also sets out when it is and is not appropriate to use the camera.

We found that on at least one of the occasions Mr G complained about, staff had not informed prisoners that they were being filmed and so it was, in essence, a covert use of the cameras. On two of the occasions in Mr G's complaint, we did not consider, given the evidence provided, that the prisoners' behaviour had warranted filming by BWVC and so also contravened the national policy.

We upheld Mr G's complaint and made a recommendation to remind staff about the proper use of BWVC, which the prison accepted.

Equalities

Complaints that raise equalities issues, although forming a small proportion of all complaints investigated, are often among the more troubling we receive. We are also aware that a number of other complaints, while not on the face of it about equalities, raise questions about potentially discriminatory practices. We are looking at how we can use our new case management system to better record the equalities issues raised by the complaints we receive – whether that is related to the complainant's gender, ethnicity, disability or other protected characteristics.

In this reporting year, we completed the field work for our research study into prisoners', particularly Black, Asian and minority ethnic prisoners, experiences of the complaints process. The findings will be published in 2020/21 and will include actions and learning for both HMPPS and the PPO.

Mr H complained Muslim prisoners were routinely expected to remove their religious headwear during rub down searches. He said that this was contrary to the relevant HMPPS policy which noted that prisoners should only be asked to remove headwear after a positive indication of contraband by the hand-held metal detector, or reasonable suspicion that contraband was hidden under the headwear. Mr H said that prisoners of other religions were not expected to remove headwear and so the local policy discriminated against Muslim prisoners.

Staff responded that prisoners of all religions were expected to remove headwear, so the policy was not discriminatory. They also said that the national policy was open to interpretation and that the local policy complied with national guidelines.

Our investigation found that the prison's local searching policy was out of keeping with the national policy in important ways – including doing away with the requirement that religious headwear only be searched after a positive indication from the hand-held metal detector or on reasonable suspicion. We were also concerned that the prison's equality officer did not investigate Mr H's complaint in line with the national equality policy. We upheld Mr H's complaint and made two recommendations: that the prison bring its local searching policy in line with HMPPS policy, and that the local equalities officer receive training to better understand his responsibilities. We are waiting for evidence that the recommendations have been implemented.

Complaints from female prisoners

In 2019/20, prisoners in women's prisons made up 4% of the total prison population but only 2% of the complaints we completed. This percentage has remained static for some years now. In 2019/20, we completed 48 complaints from 26 different prisoners in the women's estate. The issues raised in these complaints were broadly similar to those we received from the male estate, including missing property, staff behaviour and adjudications.

Our planned programme of prisoner discussion groups included at least one at a women's prison and we are committed to exploring whether there are any barriers to prisoners in the women's estate making complaints to us – or indeed whether there is anything HMPPS can learn about how staff in women's prisons successfully resolve complaints at the local level.

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Ms I complained that she wanted a transfer to a prison closer to her home area, to make it easier for her children and other family to visit her. She said that she had previously been in a suitable establishment, but had subsequently been transferred 200 miles away and had been waiting for some time for the prison to arrange her transfer back.

Our investigation found that, when Ms I complained to the prison, they began the transfer process to try to move her to the prison she had specified. Her preferred prison refused to accept her back because of the high number of prisoners with complex needs they already had at their establishment. Ms I had been transferred several times during her sentence. A number of other prisons closer to her home also refused to accept her because of her previous behaviour.

When a prisoner requests a transfer, it is up to the governor of the receiving prison to decide whether or not to accept them. When making this decision, governors will naturally take the prisoner's behaviour in prison into account.

It is important for all prisoners to maintain family ties, and arguably this is even more important for women with children. However, Ms I had a long and well documented history of difficult behaviour. In the circumstances, we could not say that it was unreasonable for any of her preferred prisons to refuse to accept her. Nor could we say that her current prison had failed in their efforts to secure her transfer. We did not uphold the complaint.

Complaints from prisoners under 21

A very small percentage of the complaints we completed were from those under 21 years old (2% in 2019/20). We remain concerned that young people, for a variety of reasons, rarely escalate their complaints to us. A number of those who do complain to us, do so with the help of advocates, charities and legal representatives and we continue to work with them to understand the particular issues and concerns facing this group of prisoners. In 2020/21, we hope to host a symposium focusing on young people, to bring together colleagues with an interest in youth justice and encourage a problem-solving approach to this complex area.

The complaints we have investigated on behalf of young people illustrate the importance of staff trained, and with the right skills, to manage this group of prisoners; who understand the different operational policies that apply and the need to adopt different approaches when working with young people and children. The complaints from young people often highlight particular issues such as the appropriateness of staff use of force against them, the provision of education to those aged 18 and under, and how to manage those young people whose behaviour is particularly challenging.

Contact with their family and support networks is of paramount importance in ensuring successful reintegration into society. Young people are often placed far away from their homes, and we are concerned about cases where young people are restricted in communicating with loved ones. Both of the following case studies centre on this issue.

The Howard League raised a complaint on Mr J's behalf about his struggles to communicate with his deaf mother, and in particular the prison's failure to install a minicom to allow him to telephone her.

Our investigation found that Mr J's mother had visited him at the prison and he had not subsequently raised any concerns about her ability to visit him. However, he was not able to speak to her using a normal telephone. The relevant PSI covering ensuring equality directs that governors must consider what prisoners and visitors with a range of disabilities might reasonably need and, therefore, make reasonable adjustments.

We accepted that there were significant technical difficulties for the prison in installing a minicom, but highlighted that other prisons had managed to provide a text phone as a reasonable adjustment. The prison said that they had allowed all prisoners to use the Email a Prisoner scheme to communicate with family and friends, and was exploring whether it would be possible to install a minicom somewhere in the prison. We did not agree that the prison was actively preventing Mr J from communicating with his mother, so we partially upheld the complaint, but recommended that the prison install a minicom to support d/Deaf prisoners and their families.

Mr K, via the Howard League, complained that the prison had placed him on closed visits, and barred his partner from visiting him, for 12 months. He said that as a result of the restrictions, he had not been able to see his young child.

The prison imposed the restrictions after suspecting Mr K's partner of passing unauthorised items to him during visits. However, staff had not found any unauthorised items on Mr K or his partner before, during, or following a visit. Our investigation considered whether staff had been reasonable in their suspicions, and whether subsequent actions taken were permitted by policy, and proportionate.

We viewed CCTV footage of three visits between Mr K and his partner, and agreed that their behaviour could reasonably be viewed as suspicious. However, the relevant HMPPS rules and policies emphasise the importance of maintaining young people's family ties, and that any decision to impose closed visits or ban a visitor must be proportionate to the risk.

The prison provided evidence that other close family members had visited Mr K subsequent to the prison imposing the restrictions, and had brought his young child with them. We were satisfied, therefore, that the restrictions did not prevent Mr K from having contact with his child. We also found that the prison had correctly reviewed the decision to place Mr K on closed visits each month. However, we found that the prison had not reviewed the decision to bar visits from Mr K's partner every three months, as they should have, and she was banned from visiting Mr K for 12 months in total. We considered this to have been excessive and disproportionate to the risk posed by allowing her to visit, which could have been mitigated in other ways.

We partially upheld Mr K's complaint and recommended that Mr K's partner be allowed to visit.

Complaints from those on probation

This year, we received 294 complaints from people on probation, a 5% increase on 2018/19. However, in 2019/20 we only accepted 41 eligible complaints for investigation. Once again, a high percentage were ineligible because the complainant had not completed the NPS or CRC internal complaints procedures. We recognise that we need to work with our probation colleagues to help those on probation understand the complaints process. The planned nationalisation of offender supervision (which is due to be completed by spring 2021) will hopefully provide us with an opportunity to highlight the role of the PPO in resolving complaints about probation and the correct process for referring complaints to us.

Of the 45 probation investigations we completed this year, issues raised included community supervision, the behaviour of the complainant's offender manager, and the contents of reports written about the complainant. Occasionally, those on probation give their permission for their parents or other close relatives to make complaints on their behalf, such as in the following case. Under our Terms of Reference, the PPO has discretion to accept third party complaints when the individual is unable to make a complaint themselves.

After being recalled to prison, Mr L submitted a complaint to the NPS raising a number of grievances. At the appeal stage, the NPS concluded that, overall, Mr L's engagement with his community supervision had been inconsistent and that this had made it difficult for his offender manager to support him. The NPS did not uphold the primary element of Mr L's complaint, but acknowledged gaps in the recording of their information. They partially upheld the complaint and apologised to Mr L. The appeal panel agreed to share their findings with the staff involved so that lessons could be learnt.

Mr L's parents were unhappy with the outcome and, with Mr L's consent, complained to us. They were concerned that their son's Offender Assessment System (OASys) report, which details information about risk and protective factors in the individual's life, was inadequate. They complained about the licence conditions applied while he was living in the community, and about actions his offender manager had taken while supervising him. They were also concerned that their son's mental wellbeing had not been sufficiently considered during his supervision.

We reviewed the documents, correspondence and related evidence that the appeal panel had referred to in their investigation. We were satisfied that Mr L's complaints had been properly investigated and that the conclusions the panel reached were reasonable and justified. We were also satisfied that the recommendations made by the panel had been implemented. For those reasons, we did not uphold Mr L's complaint.

Complaints from immigration detainees

In 2019/20, we received only 23 complaints from immigration detainees. Once again, we are concerned by the low number of complaints from detainees. However, the number of people detained under immigration powers was lower in March 2020[9] when compared to the same time in the previous year and this may have contributed to the low number of complaints from detainees. We understand the compelling reasons why immigration detainees may feel unable or reluctant to complain to the PPO, but we plan to increase our visibility in the immigration estate in 2020/21, including holding a detainee engagement event in an immigration removal centre.

This reporting year, we completed 16 complaints from immigration detainees. The complaints were most commonly about missing or damaged property, and staff behaviour. We upheld five of the 16 complaints.

An area on which we continue to keep a watchful eye is the use of restraints during escorts.

The following incident occurred in January 2017 and Ms M made her complaint to PPO in March 2017 with the report itself not being fully completed until November 2018.

9 https://www.gov.uk/government/publications/immigration-statistics-year-ending-march-2020/how-many-people-are-detained-or-returned

Ms M complained that escorting officers placed her in a waist restraint belt (WRB) for a prolonged period when taking her from the immigration removal centre to the airport, for her removal flight.

Immigration escorts are undertaken by a private company (now Mitie but, at the time of the incident, Tascor). As part of the investigation we considered both the relevant national Detention Service Order and Tascor's local policies. We considered that Ms M's complaint highlighted important questions about how risk assessments informed the use of restraints in immigration escorts, and whether the use of restraints always amounted to a use of force. As a result of the investigation, we recommended that Mitie (who had by this point taken over the contract) reminded staff that applying restraints after a dynamic risk assessment amounted to a use of force, and so the use of force processes should then be followed.

Initially, the Home Office Immigration Enforcement (HOIE), who have oversight of policy, rejected the recommendation. After meeting to discuss the case with us, HOIE have now partially accepted the recommendation, acknowledging that the processes for recording use of WRB needed improvement, to ensure the application was justified, proportionate and necessary.

HOIE colleagues do not accept, however, that the passive application of WRB (when the detainee complies with the application) amounts to a use of force. We remain at odds with this interpretation of the national and local policies. We are pleased that improvements are being made to existing processes and will continue to monitor the impact of these should we receive similar complaints.

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Investigating fatal incidents

There were 308 deaths within our remit in 2019/20[10] and we also began discretionary investigations into three other deaths. This was a welcome reduction from 334 deaths in the previous year, and reflected a 7% decrease in the number of self-inflicted deaths. Nevertheless, 2019/20 still saw the fourth highest number of deaths in the last 10 years. As in previous years, most of these deaths occurred in prisons (93%).

We aim to complete investigations into deaths from natural causes within 20 weeks and investigations into self-inflicted deaths within 26 weeks. However, we sometimes have to suspend our investigations while we wait for key information, such as the cause of death, toxicology tests or a clinical review. For that reason, the case studies in this section feature deaths we have investigated during 2018/19 and not all the deaths will necessarily have taken place during the year.[11]

10 This includes one post-release death, the case of Mr E, who was technically released from prison under Home Detention Curfew two days before his death, although he remained in hospital and was never released into the community.

11 Our investigation reports are published on our website (www.ppo.gov.uk) once the inquest has taken place.

Deaths from natural causes

We began 176 investigations into deaths from natural causes in 2019/20, of which 170 were in prison. As in previous years, the majority (57%) of the deaths we investigated were from natural causes. At the time of writing, four deaths that occurred in 2019/20 had COVID-19 listed on their death certificate.[12]

In investigating deaths from natural causes, our role is primarily to consider whether the healthcare the individual received was equivalent to that he or she could have expected in the community. In doing this, we rely heavily on the clinical reviews commissioned by NHS England and the Health Inspectorate Wales.

We also examine whether security measures were proportionate to the risk posed by the individual, whether an application for compassionate release was made in appropriate circumstances, and whether dying prisoners and their families were treated with appropriate sensitivity and respect.

Healthcare

As in previous years, many of the deaths from natural causes we investigated were of men over the age of 60 (61%) and many of these died of circulatory or respiratory system problems, or of cancer. In almost all cases the health issues were diagnosed promptly. We also saw many examples of good end-of-life care delivered with compassion. A typical example is the case of Mr A.

Mr A, who was 71, was serving a 15-year sentence for sexual offences. When he arrived in prison, he told a prison GP that he was having difficulty swallowing. He was referred urgently to hospital specialists who diagnosed him with cancer of the oesophagus. He had an operation to remove the cancer and recovered well. However, the cancer returned two years later and Mr A decided not to have chemotherapy but to receive palliative care instead.

He was cared for in the prison's inpatient healthcare unit. He was seen regularly by prison healthcare staff and any problems were addressed promptly. He was also seen by staff from a local hospice who advised on pain relief medication. As his health deteriorated, the governor agreed that his cell could be left permanently unlocked to allow nursing staff free access to care for him.

The prison submitted a compassionate release application promptly when it became clear that Mr A only had months to live, but it was not approved by the Secretary of State. Prison staff stayed in regular contact with Mr A's family and provided updates on his condition.

We were satisfied that the care Mr A received was equivalent to that he could have expected to receive in the community and we commended prison staff for the compassionate end-of-life care he received.

12 At the time of writing, we had completed two investigations into these deaths. Both prisoners (one male and one female) died in hospital following admission for another condition, unrelated to COVID-19. In one case we concluded that the prisoner had almost certainly caught the virus in hospital, and in the other it was impossible to say where the virus had been contracted. We have investigated further deaths from COVID-19 in 2020/21 and we intend to publish a thematic report on these deaths later in the year.

However, not all the end-of-life care we see is good, as the case study below illustrates.

Mr B, who was 87, was serving a 16-year sentence for sexual offences. He had chronic obstructive pulmonary disease (COPD) and we found that prison healthcare staff did not adequately monitor this and that his COPD care plan did not fully meet his needs.

He also had dementia and, within a few years, it was clear that he had no idea that he was serving a sentence in prison. He became increasingly distressed and injured himself banging on the cell door at night.

We were very concerned that arguments about who was funded to assess and support Mr B's dementia meant that his needs were not met and that this significantly affected his quality of life. We considered it completely unacceptable that the situation was allowed to continue for years and that the funding issue remained unresolved at the time of Mr B's death from pneumonia.

We concluded that although prison and healthcare staff were compassionate and caring in their day-to-day dealings with Mr B, the clinical care he received in prison was not equivalent to that which he could have expected to receive in the community. As the clinical reviewer said in his report on Mr B's care: "It appears somewhere in this argument over funding that managers or clinicians in the NHS Health Board forgot that a patient was suffering at the heart of this, leading to significant distress for him, other prisoners, and indeed the [prison] staff doing their best for him."

We have also continued to see some examples of very poor healthcare for younger prisoners. Indeed, just over half of all the recommendations we made as a result of our fatal incident investigations into deaths from natural causes were about the need for improvements in healthcare.[13] These recommendations included: the need for prompt mental health assessments; care plans for long term conditions; following NICE guidelines; additional training for staff in certain medical conditions; better record-keeping and communication; ensuring prisoners attend appointments without delay; and more understanding among healthcare staff about their role in identifying prisoners who may need a mental health referral or assessment.

There has, rightly, been much emphasis in recent years on what the prison service needs to do to improve prisoner safety. However, too many of our recommendations about improvements needed in primary and mental healthcare are repeated year after year. In addition, shortages of healthcare staff are endemic in some prisons and this can have a significant effect on the safety and wellbeing of prisoners.

13 We have also made healthcare recommendations in other death categories. Please see the Recommendations section for further details.

One very troubling case was that of 21-year-old Mr C who died of a HIV-related infection. Our investigation identified a catalogue of failings by both healthcare and custodial staff.

Although healthcare staff knew that Mr C was HIV positive, he did not receive his essential anti-retroviral medication for his first five months in prison. In addition, there were no care plans in place to manage Mr C's HIV, the follow-up of essential blood tests was poor, and there were numerous missed opportunities to escalate Mr C to secondary care. Without appropriate care, his immune system was seriously weakened and the pathologist who conducted the post-mortem concluded that it was highly likely that this led to his death.

We also found that Mr C's mother was treated with gross insensitivity by prison staff. The prison did not tell Mr C's mother that he had been admitted to hospital and was seriously ill, and she found out by chance when she went to visit him at the prison the following day. Prison staff refused to tell her which hospital he was in and she had to make her own inquiries to find out. Prison staff then kept her waiting at the hospital for two and a half hours before she was allowed to see her son, by which time he was in a medically induced coma and did not regain consciousness before he died later that day.

We were also concerned that Mr C continued to be restrained even when he was in a medically induced coma.

We have also continued to see examples of poor healthcare for prisoners whose behaviour is challenging in some way. The following case study illustrates the way in which behavioural problems, perhaps caused by mental ill health, can mean that physical health problems are misinterpreted or overlooked.

Mr D, who was 35, was serving a seven-year sentence for robbery. He had been diagnosed with schizophrenic affective disorder and had taken antipsychotic medication since he was a teenager. During his time in prison, Mr D was frequently violent and often spent time in segregation units.

About three weeks before he died, Mr D was segregated again after he assaulted another prisoner. His first week in segregation was uneventful but, over the course of the next week, he vomited, stopped eating and drinking, became unsteady on his feet and appeared incapable of communicating with prison and healthcare staff. He was eventually taken to hospital by ambulance where he died 10 days later of a pulmonary embolism.

We found that, while he was in the segregation unit, Mr D was seen frequently by healthcare staff, including mental health staff. However, we were concerned that, despite his worrying and worsening symptoms, all the health assessments took place from behind a locked door and healthcare staff did not examine him in person. We considered that the failure to assess Mr D properly contributed to confusion about his diagnosis and a delay in his hospital admission.

Restraints

When prisoners have to travel outside the prison, for example to attend hospital, a risk assessment is conducted to decide the level of the security arrangements required, including restraints. The prison service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Case law on this issue is clear following a judgement in the High Court – the use of handcuffs on a prisoner who is receiving medical treatment or care must be necessary and proportionate, taking into account factors such as the prisoner's current health and mobility.[14]

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

An example is the case of Mr E, a 51-year-old Category C prisoner[15] who had had both legs amputated and used a wheelchair. About two weeks after he entered prison, he was taken to hospital with a suspected stroke which left him with left-sided weakness. He was taken back to hospital twice over the next two weeks and, on the last occasion, he remained in hospital where he died two weeks later of multiple organ failure caused by pneumonia and hepatitis C.

Although we were satisfied that Mr E received a good standard of healthcare in prison, we were concerned that he was restrained on all three occasions when he was taken to hospital. We found no evidence that the authorising managers took Mr E's physical health and mobility and his Category C status into account when deciding that he should be restrained.

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

15 Category C prisoners cannot be trusted in open conditions but are considered to be prisoners who are unlikely to make a determined escape attempt.

Self-inflicted deaths

There was a 7% drop in the number of self-inflicted deaths in 2019/20 compared to the previous year – 83 deaths compared to 89 – but the number is still too high.

It is not realistic to expect that establishments will ever be able to prevent all self-inflicted deaths. Nevertheless, we know from our investigations over many years that there are some actions that can help to reduce the number of such deaths, including:

- good quality risk assessment to identify those at most risk of suicide and self-harm (especially in the early days in custody)
- appropriate action to minimise or resolve the reasons for distress
- safety checks at appropriate intervals for those at risk
- multi-disciplinary working, especially for those with mental illness and substance misuse issues
- an effective strategy to reduce the supply of and demand for illicit drugs (which are so often associated with debt and bullying)
- staff engagement with prisoners to pick up on signs of distress
- a prompt and effective emergency response to suicide attempts

These lessons are now well-known and it is therefore troubling that many of our investigations during the year found that the same failings keep occurring and we are repeating recommendations that we have made before.

Assessment and management of risk

A key tool in helping to reduce the number of self-inflicted deaths is the prison service care planning system used to support prisoners at risk of suicide or self-harm: ACCT.[16]

The purpose of ACCT is to try to determine the level of risk, how to reduce risk and how best to monitor and support the prisoner. After an initial assessment of the prisoner's main concerns and background information, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Staff are also expected to have meaningful conversations with prisoners.

Regular multidisciplinary review meetings involving the prisoner should be held. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed and the risks reduced.

When we investigate self-inflicted deaths, we consider whether the individual's risk of suicide and self-harm was appropriately assessed and managed, and therefore whether prison staff might have been able to prevent the death.

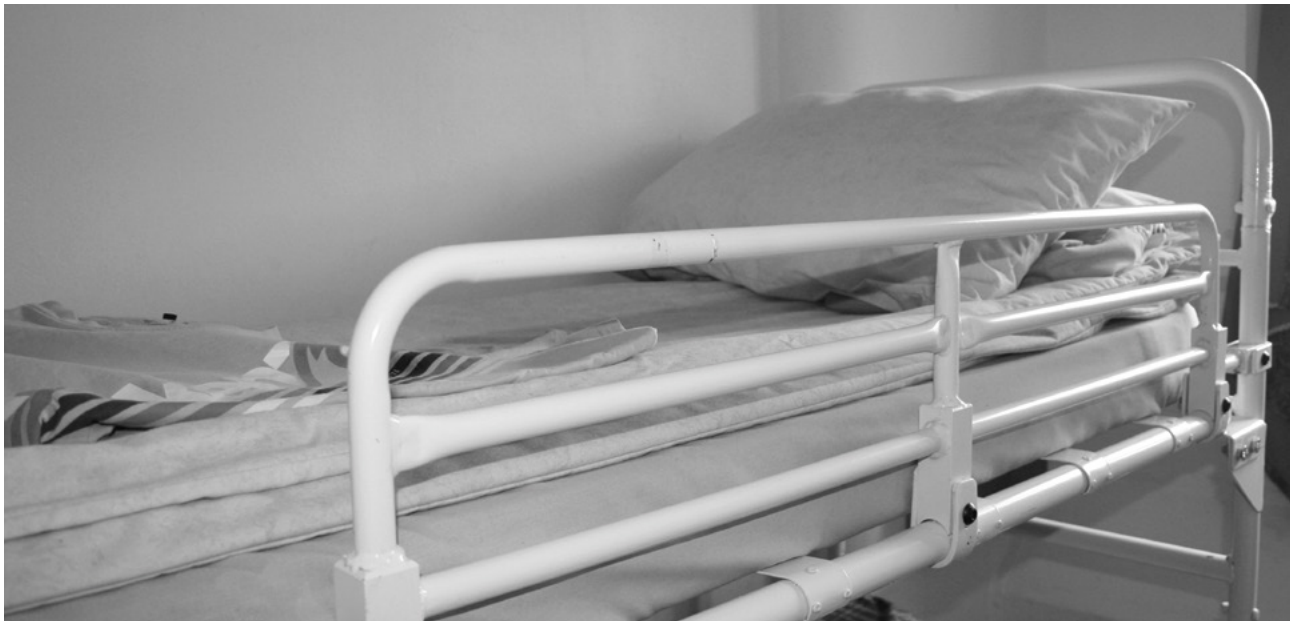
In some cases, we concluded that staff could not reasonably have been expected to foresee that the prisoner was at imminent risk of suicide.

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

One such case was that of Mr F, a 36-year-old man serving a 17-year sentence for sexual offences, who hanged himself in his cell. A few days before Mr F's death, his partner had ended their relationship and Mr F left a note saying he could not live without her. Staff did not know Mr F's relationship had ended and we were satisfied that they had no reason to consider that he was at imminent risk of suicide.

We were, however, concerned that Mr F's key worker[17] had not met him at all in the two months before his death and we considered that this may have been a missed opportunity to have known about Mr F's relationship problems and to have considered whether Mr F might be at risk.

Although staff could not have known that Mr F was at risk, we continued to see too many cases where staff failed to assess risk appropriately. A common failing is that staff place too much emphasis on their perceptions of the prisoner's state of mind based on how she or he seems or 'presents', or what they say, and do not give sufficient weight to their risk factors. The following case study illustrates this.



17 The key worker system is an important part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period. Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.

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Mr G, who was 18, was remanded to prison charged with burglary. This was his second time in custody and he had been released from the prison a few days earlier. He had been in care since the age of 14. He had been diagnosed with a personality disorder, anxiety and depression, and he had a history of substance misuse.

When he arrived, staff monitored him under ACCT procedures. He was initially checked once an hour but, the following day, his risk to himself was assessed as low and the checks were reduced to two during the day and five at night.

A few days later he received a cut lip during an argument with another prisoner. He was later placed on a disciplinary charge for assaulting another prisoner and confined to his cell. The following day, a preliminary disciplinary hearing took place. Mr G said that the prisoner he had assaulted had stolen his trainers. The full hearing was adjourned to a later date. At an ACCT review that afternoon, Mr G said he had no thoughts of suicide or self-harm, and staff assessed his risk of suicide or self-harm as low.

The following day he was found hanging in his cell. He was taken to hospital but died two days later.

Although Mr G was appropriately monitored under ACCT procedures, we considered that his risk to himself was not adequately assessed. Staff did not give sufficient weight to his significant risk factors – his age, his mental health concerns and his history of suicide attempts and self-harm – and relied too much on his assertions that he had no intention of killing himself.

We also found that the management of the ACCT procedures was very poor. Staff did not carry out two scheduled case reviews, and Mr G had only two ACCT reviews, eight days apart, during the 12 days he spent at the prison. The second case review was not multidisciplinary, staff did not maintain the ongoing record of observations as required, and one officer knowingly made a false entry.

In addition, the ACCT document did not accompany Mr G as it should have done when he moved around the prison. As a result, the senior manager who opened the disciplinary hearing, did not know Mr G was on an ACCT.

Another common failing is that staff fail to share information about risk, as the case of Mr H illustrates.

Mr H, who was 45, was serving a sentence for sexual offences. It was his first time in prison. He was prescribed medication for anxiety, which he was issued weekly and was allowed to keep in his cell. Seven weeks before his death, a prison officer found a large quantity of this medication in Mr H's cell and handed it to a pharmacy assistant. The incident was recorded in Mr H's medical record but was not shared with wing staff. Mr H continued to receive his medication weekly and to keep it in his cell.

A few days before his death Mr H received a letter from his solicitor saying that the police intended to interview him about possible further charges. Other prisoners told a supervising officer that they were concerned because Mr H appeared to be upset. A supervising officer told us that he spoke to Mr H, but that Mr H said that he did not know why the police wanted to see him and insisted he had no thoughts of suicide or self-harm. The supervising officer did not record this conversation in Mr H's records.

Three days later, Mr H was found dead in his cell, having taken an overdose of his prescription medication.

We were very concerned that no action was taken to review Mr H's risk after he was found to be stockpiling his medication. We also considered that hoarding medication and a police investigation into possible further charges were significant risk factors that should have been recorded and shared. We were not satisfied that staff understood the rationale for sharing information with each other to identify factors which could increase risk, or the benefits of using such information to make better-informed decisions and take preventative action.

Mental health

Mental ill-health is closely associated with high rates of suicide and self-harm in custody. In many of the self-inflicted deaths we have investigated, we found that the prisoner's mental health issues were not adequately addressed or that they were too severe to be managed in prison. An example is the case of Mr I.

Mr I, a 34-year-old foreign national, was remanded to prison charged with drugs offences. It was his first time in prison and he was noticeably distressed.

After three weeks, staff opened ACCT procedures when Mr I said he felt suicidal. He told a prison psychologist that he was being threatened by gang members, was worried about his court appearance, and was very depressed. Later that evening he was moved to a different cell after fighting with his cellmate who he said had threatened him with a razor. Two days later, the ACCT was closed after Mr I said he had no thoughts of suicide or self-harm.

The prison's health and wellbeing team discussed him and noted that he was anxious and depressed and had been referred to the prison GP and was on the waiting list for the anxiety support group.

Ten days later, another ACCT was opened after Mr I was found crying in his cell and said he had not eaten for several days and wanted to die. Over the following week, Mr I's mental health appeared to deteriorate. He said he was hearing voices, was distressed about traumatic events that had happened in his home country, and was not eating or sleeping. He said he thought he was going crazy and he asked repeatedly to be referred to the prison GP and mental health team. Prison staff tried to get him seen urgently by the mental health team but were told he had an appointment booked in a few days' time.

In the meantime, Mr I became increasingly distressed. He was moved to a single cell as he was not getting on with his new cellmate. He was later found with a ligature around his neck and superficial cuts to his arms, and told a nurse that he wanted to die. The prison's health and wellbeing team discussed him and agreed he would have a mental health assessment the following day. However, that evening he was found hanging in his cell. He was taken to hospital, where he died a week later.

We concluded that Mr I's healthcare was not equivalent to that which he could have expected to receive in the community. Healthcare staff did not request his community GP records until he had been in prison for five weeks. He was never seen by a GP or assessed by the mental health team. There were no clear channels by which prison officers could express concerns about his deteriorating mental health, and the prison's health and wellbeing team was not effective in expediting a GP appointment or mental health assessment.

We also considered that Mr I's risk to himself was under-estimated and that the ACCT procedures were poorly managed and did little to support him or address his risks.

In addition, we were very concerned that the cell he was moved to the day before he hanged himself had restricted daylight and was dirty and covered in graffiti. We considered that this cell was not fit for use by prisoners generally and was a particularly unsuitable environment for someone at risk of suicide or self-harm.

Prisons need to be especially vigilant about the care of prisoners who are being considered for, or are awaiting, transfer to a secure hospital.

Mr J, who was 46, had been diagnosed with anti-social and paranoid personality disorders and had a history of aggressive, violent and disruptive behaviour, both in the community and in custodial settings. He had attacked staff, prisoners and fellow patients in hospital. In 2014, he was convicted of assaulting another prisoner and was subsequently transferred to a high secure psychiatric hospital. Three years later the hospital discharged him and he was transferred back to a high security prison where he was located in the segregation unit for a period of assessment.

Almost immediately, he began to display paranoid behaviour and cut his arm and tied a noose around his neck. Over the following weeks, Mr J's mental state and behaviour deteriorated. He said that his food was being tampered with and that other prisoners were threatening him because he had been talked about in the national news. (There was no evidence for either.) He also repeatedly aggravated the cut in his arm, turning it into a serious wound.

He was managed under ACCT procedures and was put under constant supervision in a gated cell,[18] and remained under the care of the mental health team. He refused to move from his bed, frequently soiling himself, and rubbed faeces into his wound. On several occasions, Mr J damaged his arm so badly that staff put him into a body belt to prevent him from harming himself further. He often refused to eat or to let healthcare staff examine his wound.

The mental health team tried to secure a transfer back to a secure hospital. In the meantime, they and prison staff considered how best to care for Mr J while he remained in prison. A multi-disciplinary meeting developed plans to reintegrate him slowly into a normal regime and, as a first step, he was moved to a standard cell in the healthcare unit and his observations were reduced to 15-minute intervals. That evening he was found hanging in his cell and died two days later in hospital.

We were satisfied that the decision to relocate Mr J to a non-gated cell on the day of his death was carefully considered, multidisciplinary and planned over several days. While, in hindsight, the decision was not right for Mr J, we considered that the decision to end his constant supervision was taken in line with national guidelines and with his best interests in mind. It was not an unreasonable decision in the circumstances.

We were very concerned that, although prison and healthcare staff worked hard to try to care for Mr J, prison was not the right setting for someone with Mr J's complex needs.

18 A gated cell has a barred gate instead of a cell door and is designed for prisoners who require constant supervision under ACCT procedures. An officer sits outside the gate watching the prisoner 24 hours a day.

Emergency response

The PPO only investigates those cases where an individual has died. We know that there are also incidents where prisoners are successfully resuscitated after a suicide attempt, albeit sometimes with life-changing injuries. We know from this that a confident and effective emergency response can save lives.

To achieve this, it is essential that uniformed and healthcare staff understand their responsibilities during medical emergencies, including:

- using the correct emergency code to communicate the nature of a medical emergency
- entering the cell promptly to provide aid where it is safe to do so
- arriving at the scene with relevant emergency equipment
- ensuring there are no delays in calling an emergency ambulance
- escorting paramedics through the prison promptly to the scene

Unfortunately, we still see too many cases where there are significant failings in the emergency response, as the case of Mr K illustrates.

Mr K, who was 56, was serving a long sentence for sexual and violent offences. At about 5am, a prison officer doing a roll check (count) of prisoners saw Mr K lying on the floor of his cell. He told us that prisoners sometimes sleep on the floor and he thought he saw Mr K's leg move so he continued to check the other prisoners on the landing. He returned to check on Mr K about five minutes later. He knocked on Mr K's door but he did not respond. He then went to the office and telephoned the communications room and asked for another officer to come to the wing.

Another officer arrived about five minutes later and could not get a response from Mr K either. They went to the wing office and telephoned the night orderly officer to ask for permission to enter the cell as there was a prisoner lying on the floor. They were given permission and went into the cell where they found Mr K was cold and not breathing. At 5.29am, they radioed a medical emergency code blue (indicating that a prisoner is unresponsive or having difficulty breathing).

Other officers arrived and began CPR. At 5.35am the control room called an ambulance. Paramedics arrived and at 5.50am and pronounced Mr K dead shortly afterwards. The post-mortem found that he had taken an overdose of his prescription medication.

We were concerned that after an officer saw Mr K lying unresponsive on the floor of his cell, there was a delay of around 20 minutes before staff entered the cell and called an emergency medical code. There was a further six-minute delay before the control room called an ambulance. While these delays did not affect the outcome for Mr K, since he had been dead for some time when he was found, such delays could make the difference between life and death in another emergency.

Drug-related deaths

There is often a long wait before the results of toxicology tests are received. It is not, therefore, possible at the time of writing to give an exact figure for the number of drug-related deaths in 2019/20.[19]

We can say that there were 31 'other non-natural deaths' in 2019/20. This category includes a small number of cases where post-mortem and toxicology tests were unable to establish the cause of death or where there was insufficient evidence to classify a death as self-inflicted. However, in most of these deaths, an accidental or intentional drug overdose was the primary cause of death, or drug use was a contributory cause of death.

There were a further 19 deaths awaiting classification at the end of the year and experience suggests that it is likely that the majority of these deaths will also prove to have been drug-related. This suggests that there was a slight reduction in the total number of drug-related deaths in 2019/20 compared with the previous year.

It is important to say that these figures do not give a full picture of the damage that drugs are causing in prisons. Toxicology tests are not always undertaken and, even where they are, they will not always detect some of the many strains of psychoactive substances. And it is impossible to say how many suicides may have been prompted by drug-related debts and bullying or by the mood-altering effects of drugs.

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It is important to say that these figures do not give a full picture of the damage that drugs are causing in prisons.

We continued to be concerned about the apparent ease with which prisoners were able to obtain drugs, even in segregation units and high security prisons. We welcomed HMPPS's new strategy and guidance for reducing the supply of and demand for drugs in prisons, issued in April 2019. This required each prison to identify their key drug issues and develop a local drugs strategy to address these issues by September 2019. This may have produced the apparent slight drop in the number of drug-related deaths, but it is too early to say whether this trend will continue and drugs remained a substantial factor in prison deaths in 2019/20.

We continued to see deaths related to the use of psychoactive substances (PS), sometimes called 'spice' or 'mamba'. These drugs can affect people in a number of ways, including increasing the heart rate, raising blood pressure, reducing blood supply to the heart and causing vomiting, and can be particularly dangerous when taken in combination with some prescription medications. There is also evidence that they can precipitate or exacerbate the deterioration of mental health, with links to suicide or self-harm.

19 The PPO does not classify deaths as being drug related. Please see the About the data section for further details about other non-natural cause deaths.

The following case studies illustrate some of the ways in which drugs contribute to deaths in prisons.

Mr L, who was 33, was serving a sentence for burglary at the time of his death. He had a long history of substance misuse, anxiety, depression and self-harm. He was regularly found under the influence of PS in prison and had a history of getting into debt and then climbing onto the safety netting between landings to secure a move to the segregation unit away from those he owed money to. He received support from the prison's drug and alcohol recovery team and the mental health team and was regularly advised about the dangers of illicit drug use, but he continued to use PS regularly.

One afternoon, Mr L climbed onto the netting between landings on the wing while under the influence of PS, slipped and fell some 12 feet to the floor. Prison nurses and ambulance paramedics provided emergency aid and took him to hospital. Mr L did not regain consciousness and died from head injuries a week later.

Toxicology tests confirmed he had taken PS before his fall. Although a significant number of prisoners who knew Mr L said he was not being bullied, his drug debts clearly caused him stress and prompted behaviours that ultimately led to his death.

Although PS featured in many of the drug-related deaths we investigated, we also found deaths caused by other illicit drugs, such as cocaine and heroin, and prescription drugs. Prescription drugs are highly tradeable and prisons' drug strategies need to include robust measures to prevent drugs being secreted and diverted when they are administered. The following case study illustrates the way in which drug misuse can cause the death of even young, fit men.

Mr M, who was 22, was serving a sentence for driving offences. Prison staff received intelligence that Mr M was dealing drugs on the wing. As a result, they searched his cell twice in the two months before his death, but found no illicit items. He was found dead in his bed one morning when his cell was unlocked.

Post-mortem toxicology tests showed that before his death Mr M had used PS and several prescription medications: buprenorphine (an opioid drug prescribed in the treatment of heroin addiction), diazepam and zopiclone (both tranquillisers), and pregabalin (used to treat epilepsy, anxiety and nerve pain but also widely misused for its euphoric effects). The post-mortem report explained that these drugs, which Mr M was not prescribed, have overlapping side effects, which include respiratory depression, coma and death, and it was likely that they had caused Mr M's death when taken together. There was nothing to suggest that Mr M's death was anything but an accident. We were very concerned that he had been able to obtain so many illicit prescription drugs with apparent ease.

Homicides

There were two apparent homicides in 2019/20, compared to four in 2018/19, and eight the previous year. Although the killing of those in the care of the state is a particularly serious matter, these are some of the hardest deaths to learn lessons from, partly because the circumstances tend to be unique in each case, and partly because the PPO can only complete an investigation once any criminal proceedings have been completed. The homicide in the following case study took place in 2018, but we were only able to complete our investigation in 2019/20.

Mr N, who was 39, had been in prison on remand for two weeks when he was found unresponsive in his cell during the afternoon association period. He was taken to hospital but died that evening of a bleed on the brain. Another prisoner, Mr O, was identified as having punched Mr N and was subsequently convicted of his manslaughter.

The reasons for Mr O's assault on Mr N are unknown. We were satisfied that prison staff had no reason to consider that there were any links between Mr N and Mr O, or that Mr N was at risk from Mr O.

However, Mr O had a history of violence and was judged to present a high risk to others in general. His risk to others was believed to increase when he used PS. Five days before Mr N's death, Mr O had admitted he was taking PS daily, and asked a mental health nurse for help. He declined to see her later that day and a planned appointment had not taken place before Mr N's death.

We were concerned that Mr O was able to use PS so frequently and that this was not communicated to healthcare staff and the substance misuse team each time, as it should have been. This might have led to earlier and more urgent assessment of Mr O's PS use and its effect on his mental health – although there is no way of knowing whether that might have prevented the assault on Mr N.

Female prisoners

In 2019/20, six women died in prison (a lower number than in the two preceding years). Four of the deaths were self-inflicted, one was drug related and in one the cause of death was not ascertained.

Ms P was serving a sentence for theft and sexual assault. She had a history of drug and alcohol abuse and, while in prison, she underwent a methadone detoxification programme and worked with a substance misuse recovery worker. She was released on licence and was required to live at an approved premises (AP) as part of her licence conditions. She was given a methadone prescription to be administered by a local pharmacy.

Ms P arrived at the AP after curfew time that night and admitted she had drunk alcohol. The next morning, she was seen apparently buying drugs, and drugs were later found in her room. After two days she left the AP and did not return. Ten days after that, the police found her intoxicated in the street. She was taken to hospital where she spent several hours before being taken into police custody.

The next day she was sent back to prison. Reception staff noted that she looked unwell. Ms P told the officers she had been smoking and injecting heroin and cocaine and drinking strong lager every day. She said she had no thoughts of suicide or self-harm. As she was showing signs of withdrawal from drugs, she was seen by a prison GP and was prescribed methadone.

Healthcare support workers checked on Ms P hourly during the night, between midnight and 5.15am. Each time, they noted that Ms P appeared to be asleep. An officer carried out a roll check (count of prisoners) at 5.30am, and said that Ms P appeared to be asleep. She was found dead when she was unlocked at 8.30am. The post-mortem examination and toxicology tests were unable to determine the cause of Ms P's death.

We were told that all prisoners are checked hourly overnight in the first night centre to ensure that each prisoner is alive and well. However, the staff checking on Ms P just looked into the cell and noted that she appeared to be asleep; they did not satisfy themselves that she was alive. Ms P had been dead for some time when she was discovered at 8.30am and it is likely that she was dead when some of the checks were carried out.

We concluded that the checks were inadequate and that the prison needs to ensure that staff are clear on the purpose of the checks and that they assure themselves that prisoners are alive and well.

In the self-inflicted deaths of women, we found failings in risk assessment similar to those we often find in our investigations into the self-inflicted deaths of men in prison, as the following case illustrates.

Ms Q, who was 53, was serving a life sentence for murder. She had a long history of drug misuse, self-harm, volatile and impulsive behaviour and had been diagnosed with an emotionally unstable personality disorder. A few years into her sentence, she was transferred to a special unit for women with a personality disorder but she did not settle there. She was moved out urgently after she took a member of staff hostage, armed with a pair of scissors.

When Ms Q arrived at her new prison, she immediately became violent and was located in the segregation unit. She cut herself and staff began to monitor her under ACCT procedures. Managers concluded that she could not be held safely elsewhere in the prison so she remained in the segregation unit under constant observation.

Over the next few days, Ms Q's mood varied, with occasional outbursts against staff. After four days, her observations were reduced to four per hour. The next morning an officer found her standing on a bin, tying a piece of fabric to her doorframe. In the afternoon a multi-disciplinary meeting, which did not know about the incident in the morning, decided to move her to a standard wing as soon as a place became available.

The next day Ms Q was agitated and abusive to staff but she denied any thoughts of wanting to harm herself at an ACCT review and her observations were reduced to two per hour. She was found hanging in her cell that afternoon. She was resuscitated and taken to hospital but did not regain consciousness and died six days later.

Prisoners under ACCT management should only be segregated in exceptional circumstances. We were satisfied that other locations were considered and that the decision to keep Ms Q in the segregation unit was not unreasonable in the circumstances. We are also satisfied that the prison intended to transfer her to a standard wing as soon as possible and that Ms Q was told this. In line with prison service policy, Ms Q was seen by healthcare staff, by a member of the chaplaincy, and by a senior manager every day, and she was given a radio and in-cell hobby materials to help keep her occupied while she was segregated.

ACCT procedures were appropriately opened after Ms Q cut herself. However, when Ms Q was seen making a possible attempt to tie a noose, this should have triggered a review of her risk level. We were very concerned that this did not happen and that decisions were made at the complex needs meeting that afternoon and at the ACCT review the following day without anyone knowing about the incident.

Even without knowledge of the incident, we considered that the decision to reduce Ms Q's level of observations to two per hour was premature and appears to have been based on her presentation at the ACCT review, rather than consideration of her ongoing risk factors.

Young people

Four young people under 21 (all male) died in prisons and young offender institutions in 2019/20 (compared to one in 2018/19, and four the year before). Three of the deaths were self-inflicted and one was from natural causes. There were a further two deaths of prisoners aged 21 (both from natural causes), including Mr C whose death is discussed on page 40.

R, who was 16, was on remand on charges of murder when he was found unresponsive in his room. He was taken to hospital but did not respond to treatment and died the next day.

The post-mortem found that R died of a brain haemorrhage caused by a tangle of abnormal blood vessels in his brain which had probably been present since birth without showing symptoms. Our investigation found that R's clinical care was equivalent to that which he could have expected to have received in the community. He had a rare condition, with no history of problems with his brain, and we were satisfied that prison healthcare staff could not reasonably have predicted his death.

Where the self-inflicted deaths of young people are concerned, their youth, challenging behaviour and often traumatic lives can leave them particularly vulnerable and isolated in custody and need to be seen as risk factors. The death of Mr G on page 44 is one example of this. Another example was the death of Mr S.

Mr S, who was 20, hanged himself less than four days after being recalled to prison. Reception staff noted that he said he had no thoughts of suicide or self-harm, but they failed to identify that he had several risk factors, including that he had a history of depression and self-harm and that he had been recalled to prison for violent offences against his partner. We were concerned that staff did not consider whether he should be managed under ACCT procedures.

Mr S told staff he had recently been prescribed antidepressants in the community and asked to be referred to the mental health team. Although this was done, we were very concerned that a mental health practitioner discharged Mr S from the mental health team without seeing him.

We concluded that Mr S's risk to himself was underestimated and there was a missed opportunity to provide him with support.

Immigration removal centres

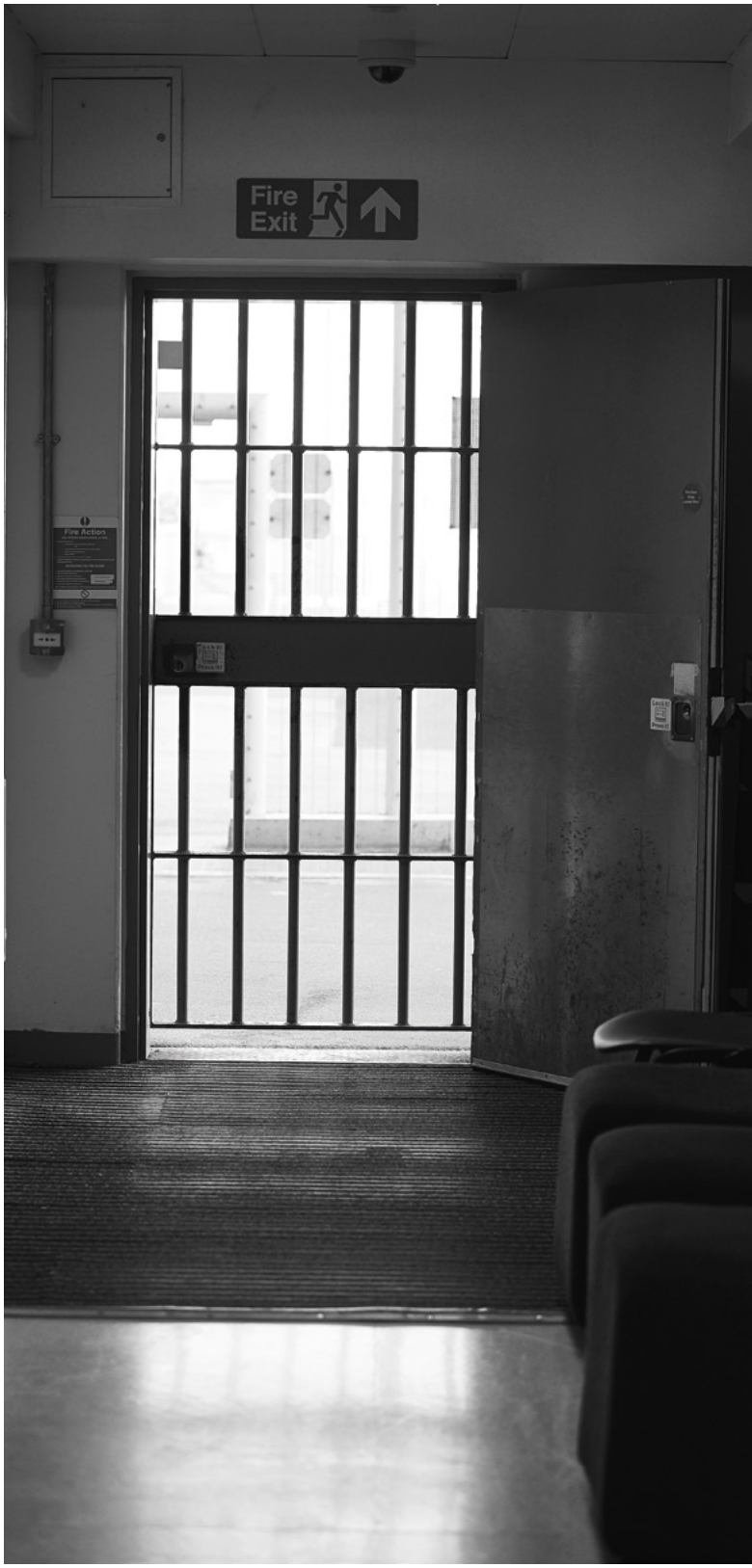
One detainee died in an immigration removal centre (IRC) in 2019/20, a death from natural causes.

Mr T, who was 36, was denied entry to the UK and detained in an IRC pending removal to his home country. Three weeks later, he was found dead in his room. The post-mortem found that he died of a spontaneous brain haemorrhage.

Our investigation found that, Mr T's blood pressure was raised during his initial health screen but that healthcare staff did not investigate this further. Healthcare staff also failed to investigate why Mr T requested paracetamol for recurring headaches on eight occasions in the two weeks before his death.

When Mr T was found unresponsive in his room, healthcare staff failed to check for a pulse or to assess his level of consciousness and, although rigor mortis had set in, they made prolonged and inappropriate attempts at CPR.

We were not satisfied that the healthcare Mr T received at the IRC was equivalent to that which he could have expected to receive in the community. As this was not the first time we had raised similar concerns, we escalated our concerns to the Head of Operations in Detention and Escorting Services in the Home Office.



Approved premises

We began investigations into 17 deaths in APs[20] during 2019/20, including the deaths of two women. Five of the deaths, including one of the women's, were from natural causes; five were drug related and two were categorised as 'other non-natural'; two were self-inflicted and three are awaiting classification (although they seem likely to be drug-related).

Residents of APs are responsible for their own healthcare and are expected to register with a GP. In most of the deaths from natural causes, we found that there was nothing that anyone could have done to prevent the death and we made no recommendations. However, this was not always the case as the following case study illustrates.

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>
> We continue to be concerned at the number of drug-related deaths among AP residents.

Mr U, who was 76, was serving a sentence for sexual offences. He was released on licence to live in an AP. Shortly after arriving, he left to go to a nearby shop but never returned. He collapsed in the town centre that evening and was taken to hospital by ambulance, but was pronounced dead of heart failure shortly after he arrived.

Mr U had been diagnosed with heart disease and diabetes before he went to prison and was prescribed appropriate medication in prison. However, he frequently failed to take his medication and, around a month before his release, he stopped collecting it altogether. He was released from prison without any medication in his possession.

We were satisfied that the AP staff could not have foreseen or prevented Mr U's death. However, we concluded that the clinical care Mr U received in prison was not equivalent to that he could have expected to receive in the community – although we could not say whether Mr U's failure to take his medication resulted in his death. He was on critical medications for heart disease and diabetes, and we considered that prison healthcare staff should have done more to monitor his medication compliance and to encourage him to take his medication. We also considered that his mental capacity to refuse his medication should have been assessed and that he should not have been released without a supply of his medication.

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

A separate issue arose in the case of Mr V.

Mr V, who was 64, was serving a short sentence for sexual offences. He was released from prison to live at an AP but never arrived there. Our investigation found that his wife had met him at the prison gate and told him their marriage was over. A few hours later he was found hanged in a local park. We were satisfied that his death could not have been foreseen or prevented.

We continue to be concerned at the number of drug-related deaths among AP residents. There is a high prevalence of people with substance misuse issues in prisons[21] and, as most AP residents have been released from prison on licence, substance misuse is one of the key issues AP staff must manage.[22]

As we said in a Learning Lessons Bulletin, Approved Premises – substance misuse,[23] published in 2017, the risk of mortality for those who have just left prison is significantly higher than mortality in the general population, and this risk is especially stark in relation to substance misuse. There is a high risk of overdose in the first month after release; the first few days after release is the peak period.[24]

This may be due to changes in individual tolerance for opiates, which can decrease in a matter of days after a period of abstinence, and/or a lack of understanding of the strength of the illicit substances which may be available in the community. The risk of overdose is particularly acute when the resident has undertaken a detoxification programme in prison.

Some of the cases we investigated demonstrated insufficient focus by AP staff on the risk of relapse and overdose, as the following case study illustrates.

Mr W, who was 33, was serving a sentence for a violent offence. He had a history of drug and alcohol misuse.

He was released on licence to live at an AP. His licence required him to be regularly tested for drugs. His offender manager (probation officer) recorded in his release plan that he should be notified if there was any evidence that Mr W was taking drugs, and that Mr W would be recalled to prison if he failed to address his substance misuse issues in the community.

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

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

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

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

About a week after Mr W arrived at the AP, drug paraphernalia was found in his room and he was issued with a warning. On the same day, Mr W tested positive for cannabis. The next day, he tested positive for cannabis again. Mr W was not tested for drugs again before he died.

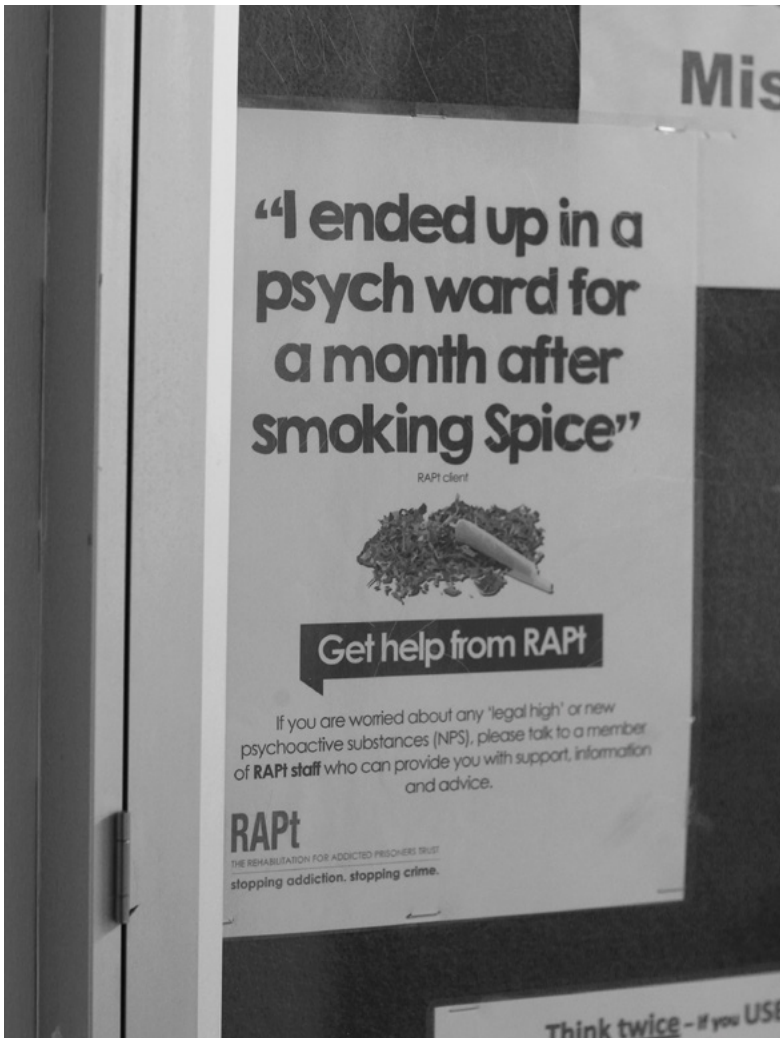
Nine days later, AP staff found Mr W unresponsive on all fours in his room. They concluded that Mr W had taken drugs and decided to wait for him to recover. When they found Mr W still in the same position and still unresponsive 35 minutes later, they went back to the office and telephoned the duty manager, who told them to call an ambulance immediately.

They called an ambulance but did not follow the ambulance service's instructions immediately and delayed for five minutes before starting resuscitation efforts. Paramedics arrived a few minutes later but Mr W could not be resuscitated. The post-mortem found he died of heroin toxicity.

We were concerned that AP staff did not fully understand their responsibility to challenge Mr W's substance misuse issues. We recommended that the AP manager introduce a local substance misuse policy as a matter of urgency.

We were also very concerned that the emergency response was poor. AP staff showed poor judgement when they found Mr W unresponsive and suspected he had taken drugs. They did not act with any urgency, did not attempt first aid and struggled to follow the ambulance service's instructions. We cannot say if the outcome might have been different for Mr W if they had responded differently, but any delay in a medical emergency may be critical.

In several investigations dating back to 2016, we have recommended that the National Probation Service review its drugs strategy for APs. We have been told in response that they are working on a revised strategy, which they aim to roll out nationally over the course of 2020. While this is encouraging, we are concerned that this strategy has been in the development stage for a long time and we consider that urgent action is now needed to ensure it is implemented at the earliest opportunity.



Discretionary investigations

During the year we were asked by the Prisons Minister to undertake a discretionary investigation into an apparent stillbirth in a women's prison after a woman gave birth alone in her cell. This investigation will be completed in 2020/21.

We also undertook two discretionary investigations into deaths in courts where the individuals were under the supervision of PECS[25] staff.[26]

Mr X, who was 18, died in hospital four days after strangling himself with his trousers in a court cell while awaiting trial. He had a significant history of mental illness, substance misuse, violence and attempted suicide. His mental health had deteriorated in the days before his death and he had talked of killing himself.

We found that Mr X's risk factors were not fully communicated by the police or by the mental health nurse who saw him at court. However, we also found that court custody staff were inadequately trained to recognise risk. We made recommendations designed to ensure that the lessons from Mr X's death are learned across all areas covered by the PECS contract.

Mr Y, who was 55, died in hospital two months after drinking acid in the dock after he was given a prison sentence for fraud. Although Mr Y had a recent history of serious self-harm, court staff were not aware of this and we were satisfied that they could not have predicted Mr Y's actions. However, we considered that the dock officer made an error of judgement when she allowed Mr Y to take his flask into the dock after he had declined to take a sip test. The company responsible for security in court docks have since amended their standard operating procedures and defendants are no longer allowed to bring their own drinks into the dock.

We investigated another death in a court cell in 2018/19 and, although the circumstances of each of these three deaths have been unique, we hope that our investigations will contribute to safer procedures in an area that has previously received relatively little attention.

25 PECS provides escort services, moving people between prisons or police stations for court appearances, and also provides court custody services in many courts. The service is provided by two private sector companies: Serco and GEOAmey.

26 We also investigated one post-release death, the case of Mr E, who was technically released from prison under Home Detention Curfew two days before his death, although he remained in hospital and was never released into the community.

Appendices

Recommendations

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

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

For complaints, the organisation must confirm whether they accept any recommendations and must provide evidence of implementation. When public sector prisons do not accept a recommendation, the Director General of Prisons must notify the PPO. For other services in remit, and for privately managed prisons, a designated senior manager must respond.

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

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

Complaints

We count recommendations about complaints in cases where we have issued the final report within the financial year. Recommendations can be either amended or removed, at any point up until a case has been closed.

In 2019/20, we made 686 recommendations across 282 cases.

We are awaiting a response to just over a third of these recommendations. We have had one recommendation rejected and one recommendation has been withdrawn. The remaining 432 recommendations have been accepted, and we have received evidence of implementation in 80% of these.

In 31% of recommendations, we advised a governor or director to issue a notice to staff, reminding them about a policy or procedure. In 14%, we recommended revising a policy or procedure.

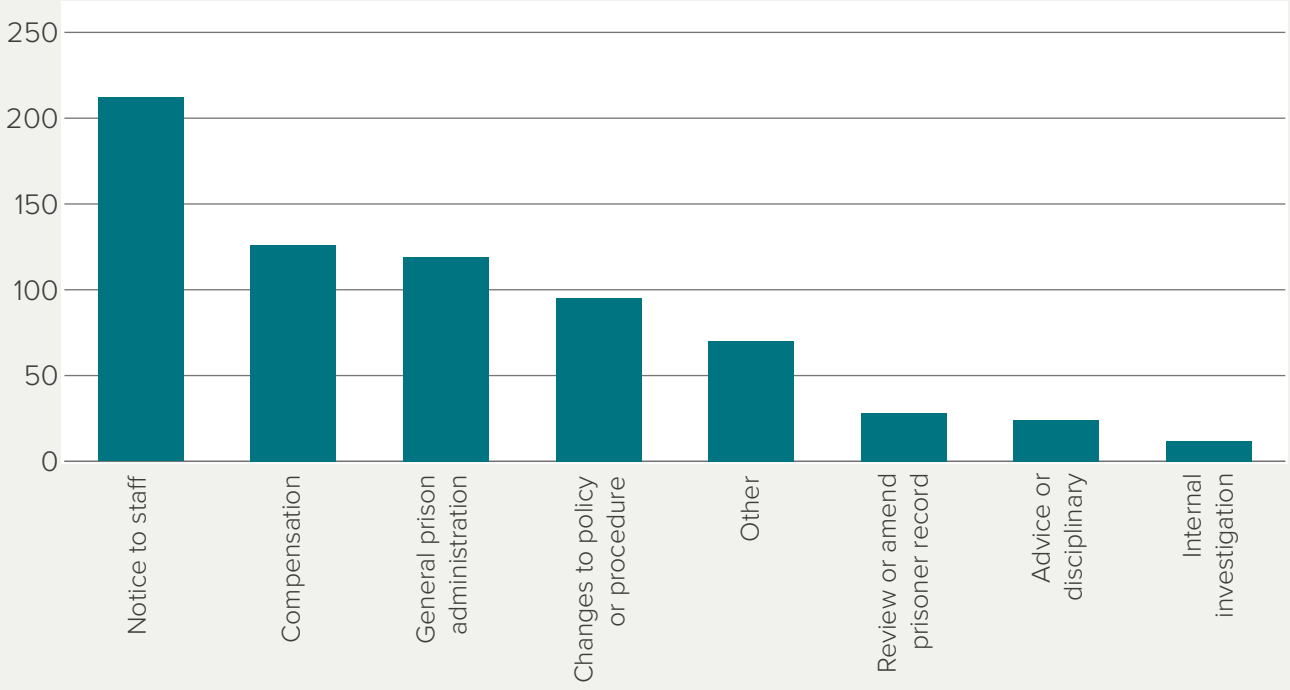
18% of our recommendations were to provide compensation to the complainant. 75% of these resulted from complaints about property.

12% of our recommendations were to issue the complainant an apology.

Other recommendations related to training for staff, conducting an audit of procedures, issuing a notice to prisoners or repairing and replacing equipment.

At the beginning of the financial year, the PPO began using a new case management system, PPUD. This change in process impacted on how we categorise recommendations. Therefore, the recommendation categories in the below 'Complaint recommendations, by action' chart differ slightly to last year's.

Complaint recommendations, by action (2019/20)



Fatal incidents

In 2019/20, we issued 341 final investigation reports following deaths in custody and made recommendations in 293 of these cases.

We made 1,050 recommendations, an average of 3.6 per case.

At the time of writing, most of our recommendations had been accepted (844) and we were awaiting the service response to the 203 remaining recommendations. Two of our recommendations were rejected by HMPPS and one recommendation was no longer applicable as the situation had changed.

The most common category of our recommendations related to healthcare provision (30%), an increase from 19% in the previous year. Healthcare provision was followed by emergency response (15%), substance misuse (9%) and suicide and self-harm prevention (8%).

Natural cause deaths

Just over half of our recommendations into natural cause deaths (51%) related to healthcare provision. 16% related to restraints and bed watch.

Recommendations relating to healthcare provision included having robust record-keeping, and following NICE guidance. They also included ensuring both attendance at hospital appointments and care of prisoners during transfers, and consistent use of the National Early Warning System (NEWS) tool to monitor any deterioration in a prisoner's health.

Recommendations relating to restraints included ensuring staff are undertaking risk assessments in line with case law when prisoners are escorted to and admitted to hospital.

Self-inflicted deaths

22% of our recommendations for self-inflicted deaths related to suicide and self-harm prevention procedures (known as ACCT) and 18% related to emergency response.

Recommendations relating to suicide and self-harm prevention included following the ACCT procedures correctly. They also included making proper use of care maps (plans for care, support and interventions), holding multidisciplinary case reviews for prisoners at risk, and assessing prisoners' risk to themselves on the basis of their risk factors (and not just relying on what they say or how they present).

Recommendations relating to emergency response included ensuring staff act promptly in a life-threatening situation and knowing their responsibilities, entering cells without unnecessary delay and using the medical emergency code system, as well as understanding when to attempt resuscitation.

Other non-natural deaths

27% of recommendations for other non-natural cause deaths related to substance misuse and 27% related to emergency response.

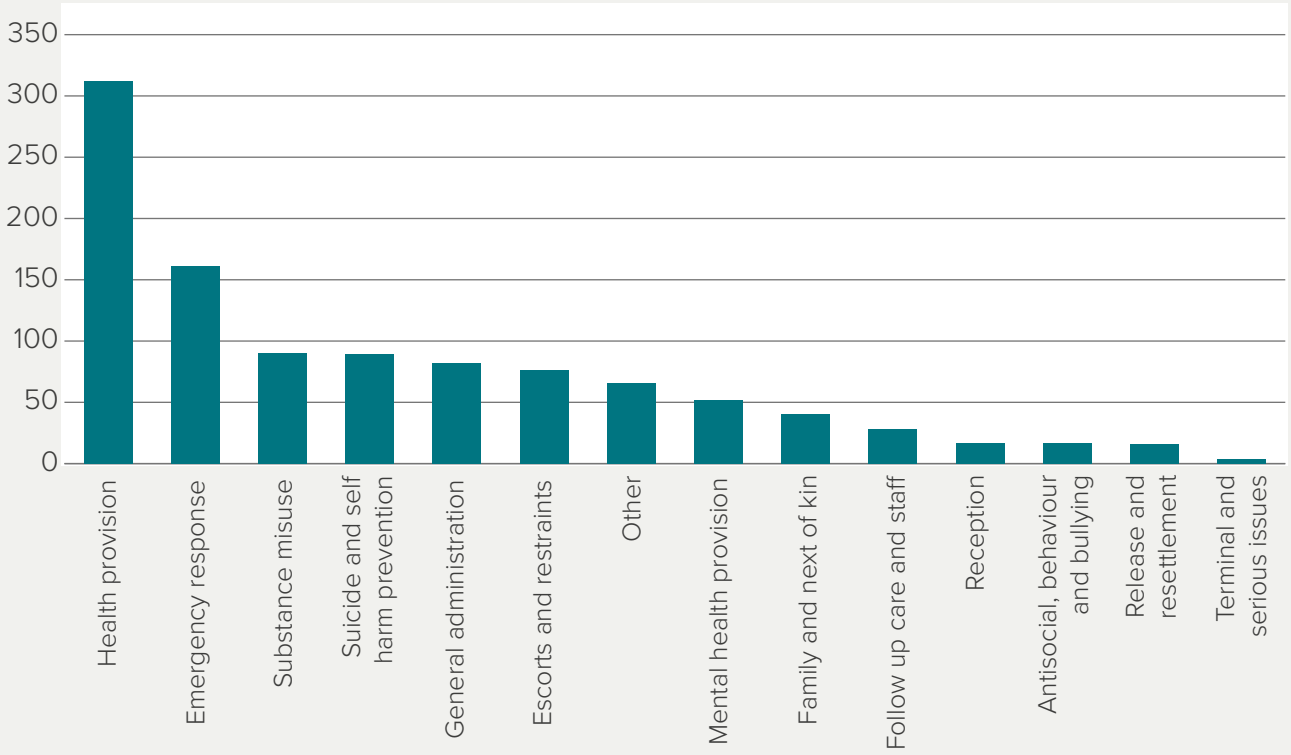
Recommendations relating to substance misuse included the need for prisons to have strategies for reducing the supply and demand of drugs in prisons, recording intelligence about the use or trafficking of drugs, and referring prisoners for substance misuse support.

Recommendations relating to emergency response were similar to those made in cases of self-inflicted deaths and included ensuring staff know their responsibilities, entering cells without unnecessary delay and using the medical emergency code system, as well as understanding resuscitation.

Homicides

We issued four final report investigations into homicides in 2019/20 and made recommendations in all four cases. Four out of the nine recommendations related to substance misuse.

Recommendations following deaths, by category (2019/20)



Stakeholder feedback – emerging findings

We routinely collect feedback from our stakeholders to understand how they engage with our work, their level of satisfaction and their opinions as to how we can improve. To that end, the PPO runs four rolling stakeholder surveys to facilitate feedback broadly from:

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

General stakeholder survey

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

We received 82 responses in 2019/20, compared to 174 responses in 2018/19. The survey ran throughout March 2020 and responses came from prisons (including operational staff, non-operational staff, business staff and other services such as chaplaincy), probation, healthcare services and central government.

Overall satisfaction

- 63 of the 82 respondents rated the PPO overall as satisfactory or better

Timeliness

- Of the 32 respondents who had been involved in complaints investigations, 20 respondents were satisfied or very satisfied with the time it took
- Out of the 34 respondents who had been involved in fatal incident investigations, 18 respondents were satisfied or very satisfied with the time it took

Reports

- Of the 40 respondents who had read PPO reports of investigations (both fatal incidents and complaints) they have been involved in in the last 12 months, 38 respondents found the reports very clear or quite clear
- Of the 40 respondents who had read PPO reports of investigations they have been involved in in the last 12 months, almost all the respondents who had read reports (38) thought that they contained the right amount of detail
- 49 out of the 82 respondents found last year's annual report useful or quite useful
- 53 respondents had said they had visited the PPO website in the last 12 months – of those, 50 reported it was very easy or quite easy to find what they were looking for
- 48 of the 82 respondents stated they found they found the website very useful or quite useful

No involvement

It is worth mentioning that, throughout the results, a proportion of respondents had not been involved, or had any experience, with the PPO within the last 12 months. 29 respondents had not been involved with any PPO investigations during the last 12 months where they had done more than just read the report.

Impressions of the PPO

- 63 respondents (of the 82 that answered the question) agreed or strongly agreed that the PPO is respectful
- 51 (of the 82 that answered the question) respondents agreed or strongly agreed that the PPO is fair
- 51 (of the 82 that answered the question) respondents agreed or strongly agreed that the PPO is dedicated
- 48 (of the 82 that answered the question) respondents agreed or strongly agreed that the PPO is independent
- 48 (of the 82 that answered the question) respondents agreed or strongly agreed that the PPO is impartial
- 47 (of the 82 that answered the question) respondents agreed or strongly agreed that the PPO is inclusive

Post-investigation survey

Following each fatal incident investigation, we send our post-investigation survey to prison liaison officers, establishment heads and healthcare leads within the establishment. We ask that these stakeholders respond to the survey about specific investigations. We also survey coroners at the end of the year about their overall experiences with fatal incident investigations. The survey asks questions about their communication with the investigator, the quality of the investigation and resulting report, and what changed as a result of the investigation. The fatal incident post-investigation survey to prison liaison officers, establishment heads and healthcare leads was not run in March 2020 due to changes in our working practices due to the COVID-19 pandemic.

We received 163 responses in 2019/20. This is a 7% decrease from last year, when we received 175 responses. We received 84 responses from liaison officers, 44 responses from establishment heads, 24 responses from healthcare leads and 11 responses from coroners.

Overall satisfaction

- 62 respondents (of the 79 that answered the question) rated the quality of the investigation as good or very good

Communication

- 88% of respondents were satisfied or very satisfied with the communication they had with the PPO
- 91% of respondents (of the 152 who answered the question) who worked in establishments said the PPO investigator contacted them promptly following the death
- 74 respondents (of the 84 that answered the question) said that the investigation process was explained to them

Timeliness

- 84% of respondents were satisfied or very satisfied with the time it took the PPO to complete the investigation

Reports

- 58 respondents (of the 63 that answered the question) stated the report we issued met their expectations
- 73 (of the 74 that answered the question) said that the PPO reports were either quite clear or very clear

- 67 (of the 74 that answered the question) said they found the recommendations useful or very useful
- 49 (of the 54 that answered the question) found the recommendations very fair or fair
- 62 (of the 65 that answered the question) found the recommendations to be clear or very clear

Impact

- 89% of respondents agreed or strongly agreed that the PPO is respectful
- 88% of respondents agreed or strongly agreed that the PPO is fair
- 88% of respondents agreed or strongly agreed that the PPO is dedicated
- 87% of respondents agreed or strongly agreed that the PPO is independent
- 85% of respondents agreed or strongly agreed that the PPO is impartial
- 84% of respondents agreed or strongly agreed that the PPO is inclusive

Bereaved families' survey

We also send surveys to families of the deceased following our investigations of deaths in custody. This year, a paper questionnaire was sent to bereaved families three months after the final investigation report was issued. For this reason, the data analysed for this report is reflective of cases where the final report was issued up to November 2019, as next of kin were last sampled in February 2020. The data collection was paused due to the COVID-19 pandemic.

We asked families to provide feedback on several aspects of their interaction with the PPO, as well as how satisfied they were with our investigation and report.

Responses

- We have received 23 responses so far during this data collection period, compared with 41 responses received in 2018/19

Overall satisfaction

- 9 out of 19 respondents who answered the question felt the draft report met their expectations

PPO contact

- 7 respondents said they received the right amount of contact with the PPO during the investigation, while another 7 respondents felt there was not enough contact
- 8 respondents stated that there had been no contact at all during the investigation

PPO communication

- Just under half of respondents (10 out of 21 who answered) said they were satisfied or very satisfied with the communication

Impact

- 13 out of 22 respondents agreed or strongly agreed that the PPO was respectful
- 11 out of 20 respondents agreed or strongly agreed that the PPO was fair
- 9 out of 20 respondents agreed or strongly agreed that the PPO was independent
- 9 out of 20 respondents agreed or strongly agreed that the PPO was dedicated

- 9 out of 22 respondents agreed or strongly agreed that the PPO was impartial
- 8 out of 21 respondents agreed or strongly agreed that the PPO was inclusive

Complainants' survey

We send surveys to a sample of those whose complaints we have investigated in the past year – both to those whose complaints were upheld, and those we did not uphold. We also sample those who have contacted us, but whose complaints were ineligible. We send our surveys two months after the case has been closed, to allow for a rest period where any potential final changes may be made. For this reason, the data analysed for this report is reflective of cases closed up to December 2019, as complainants were last sampled in February 2020. The data collection was paused due to the COVID-19 pandemic.

We received 299 responses in 2019/20, in comparison with 338 responses in 2018/19:

- 120 responses came from those whose complaints were ineligible – these complaints were not investigated, and the complainants received letters explaining why
- 179 respondents had eligible complaints – 92 had their complaints upheld or partially upheld and 87 had their complaints not upheld[27]

Quality of investigation

- 47 respondents (of the 89 respondents who answered the question) whose complaints were upheld rated the quality of investigation as either good or very good
- Of those whose complaints were not upheld, 10 respondents (of the 83 who answered the question) rated the quality of investigation as either good or very good

Quality of service

- For those whose complaints were ineligible, we asked their opinion about the overall quality of the service they received
- Of the 106 who answered the question, 32 respondents rated the service they received as either good or very good

Reports and letters

- It is important that we communicate clearly and effectively with complainants, and that we write in such a way that our reasoning is understood
- 78 respondents whose complaints were upheld (of the 87 who answered the question) said the report they received was either quite clear or very clear – for those whose complaints we did not uphold, it was 51 respondents (of the 82 who answered the question)

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

- 74 respondents whose complaints were ineligible (of the 108 respondents who answered the question, 69%) said that our letter explaining why their complaint wasn't eligible was quite clear or very clear – this is a reduction compared to last year (74%)

Outcome

- 58 respondents whose complaints were upheld (of the 88 that answered the question, 66%) agreed or strongly agreed that the PPO helped them reach a satisfactory outcome to their complaint, compared to 52% last year
- In contrast, only 8 respondents whose complaints we did not uphold (of the 82 that answered the question) said we helped them achieve a satisfactory outcome
- 20 respondents, whose complaints were ineligible, agreed or strongly agreed the PPO helped them achieve a satisfactory outcome (of the 111 that answered the question)

Impact

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

- 56% (of 277 respondents that answered the question) agreed or strongly agreed that the PPO is respectful
- 43% (of 269 respondents that answered the question) agreed or strongly agreed that the PPO is inclusive
- 41% (of 273 respondents that answered the question) agreed or strongly agreed that the PPO is dedicated
- 39% (of 275 respondents that answered the question) agreed or strongly agreed that the PPO is fair
- 39% (of 277 respondents that answered the question) agreed or strongly agreed that the PPO is impartial
- 35% (of 268 respondents that answered the question) agreed or strongly agreed that the PPO is independent

About the data

Statistical data tables can be found on our website: https://www.ppo.gov.uk/about/latest-statistics/

These tables are available for those without internet access by request.

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

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

CMS to PPUD

In May 2019, the PPO moved the system it stores cases on. This means the data contained in this annual report was collected and analysed in a different way to previous annual reports.

The PPO are still adjusting to the new PPUD system and all reasonable and proportionate steps have been taken to quality assure and clean the data. If we subsequently realise an error has been made, we will update it.

Complaints

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

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

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

Complaints data contained in this report is frozen. Data for 2018/19 was frozen in April 2019, and data for 2019/20 was frozen in May and June 2020.

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

The number of eligibility letters sent in 2019/20 refers to letters of eligibility that the PPO sent to complainants in both eligible and ineligible cases. In some cases, the PPO sent multiple eligibility letters about the same case. This happens when a case does not initially meet the eligibility criteria but is later deemed to be eligible when we receive further information. In such cases, the complainant will initially receive a letter informing the complainant that their case was not eligible for investigation. This can happen several times if the complainant continues to send correspondence that would still deem their case as ineligible. However, upon receiving subsequent information from the complainant that would make their case eligible for investigation, a further and final eligibility letter is sent informing them of this change.

A completed case in 2019/20 is defined as when the draft outcome has been approved. This excludes withdrawn cases. In previous years, we defined a completed case as when a final outcome was sent. For this reason, the figures produced this year are not comparable to previous years'. We have not been able to calculate how many completed cases were completed on time due to moving over to a new case management system and the change in definition. We are continuing to explore ways to collect this data in the future. We changed the definition to align measures in complaints and fatal incidents, which already reports on draft reports, and better recognise the work done by the PPO in getting reports to draft.

Completed cases by prison estate refer to the gender category of the prison and not the individual.

Upheld cases comprise of cases which are upheld and partially upheld.

Prison population data is taken from the March 2020 population bulletin published on GOV.UK. This can be found at: https://www.gov.uk/government/statistics/prison-population-figures-2020

Fatal incidents

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

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

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

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

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

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

Fatal incident data was frozen in May 2020.

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

Initial reports are counted as having been completed 'in time' when the report is issued within 20 weeks of the date of notification for natural cause deaths, and 26 weeks for all others (including those that are unclassified at the time of notification).

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

Recommendations

Complaints

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

Recommendations can be amended/ removed at any point up until the case is closed. This means that, until the case is closed, the data is changeable. The data provided was frozen in July 2020.

Recommendations are categorised by investigators which can lead to similar recommendations being categorised differently. The apology category is included in the general prison administration category.

Fatal incidents

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

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

Surveys

General stakeholder survey: Owing to the time the general stakeholder survey was sent out, COVID-19 may, in part, be the reason we have had fewer responses compared to last year.

Bereaved families' survey: Due to the COVID-19 restrictions, at the time of writing we were unable to access any returned surveys after 23 March 2020.

Complainants' survey: Due to the COVID-19 restrictions, at the time of writing we were unable to access any returned surveys after 23 March 2020.

Throughout the surveys, some respondents did not answer all the questions. Where this is the case, it has been highlighted.

Financial data

Finance	2018/19	% of total 18/19	2019/20	% of total 19/20	Change 18/19–19/20	% change year on year
Budget allocation	£5,158,187		£5,507,000		£348,813	6%
Actuals						
Staffing costs	£5,060,428	93%	£5,055,492	93%	-£4,936	0%
Non-staff costs	£385,233	7%	£394,234	7%	£9,001	0%
Total spend	**£5,445,661**	**100%**	**£5,449,726**	**100%**	**£4,065**	**0%**
Underspend/overspend	**-£287,474**		**£57,274**		**£344,748**	**6%**

Terms of Reference

Please visit our website for our full Terms of Reference:

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

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

Prisons and Probation Ombudsman

Third Floor
10 South Colonnade
Canary Wharf
London
E14 4PU

CCS0520637768

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